

IN THE UNITED STATES DISTRICT COURT
FOR THE SOUTHERN DISTRICT OF OHIO

* * *

STACIE RAY, et al.,
Plaintiffs,

VS

Case No.
2:18-CV-00272

AMY ACTON, et al.,
Defendants.

* * *

Deposition of QUENTIN L. VAN METER,
M.D., Witness herein, called by the Plaintiffs
for examination pursuant to the Rules of Civil
Procedure, taken before me, Donald Correll, a
Notary Public in and for the State of Ohio, at
the ACLU of Ohio offices, 1108 City Park
Avenue, Suite 203, Columbus, Ohio, Suite 203,
Columbus, Ohio, on Friday, the 27th day of
September 2019, at 9:00 a.m.

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1 APPEARANCES:

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1 QUENTIN L. VAN METER, M.D.
2 of lawful age, Witness herein, having been
3 first duly cautioned and sworn, as hereinafter
4 certified, was examined and said as follows:

5 EXAMINATION

6 BY MS. INGELHART:

7 Q. Good morning.

8 A. Good morning.

9 Q. My name is Kara Ingelhart. I'm a
10 staff attorney at Lambda Legal, and I represent
11 the plaintiffs.

12 A. Okay.

13 MS. INGELHART: If we could go
14 around the table.

15 MS. BONHAM: Elizabeth Bonham,
16 ACLU of Ohio, for the plaintiffs.

17 THE WITNESS: Okay.

18 MR. BLAKE: Jason Blake, counsel
19 for defendant -- well, ODH and others.

20 THE WITNESS: Quentin Van Meter,
21 pediatric endocrinologist in private practice
22 in Atlanta, Georgia.

23 BY MS. INGELHART:

24 Q. So you've given expert testimony
25 before, right?

1 A. I have.

2 Q. Okay. But I'm still going to go
3 over some basic rules, just as a refresher. We
4 need to speak audibly for Don here, so that he
5 can get a clear record. Inevitably, one of us
6 will nod our head or shake our head to indicate
7 yes or no, but we'll need to then follow up
8 with the actual words.

9 I'm going to try very hard not to
10 talk over you to allow you all the time you
11 need to answer a question, and I'm also going
12 to try very hard to make sure that when I ask a
13 question it's clear that I'm done when I'm
14 done. If you do answer a question, I'll assume
15 that you understood it.

16 Today's just a regular
17 conversation, though you're sworn to testify
18 honestly under oath. Is there any reason that
19 you think you couldn't testify truthfully
20 today?

21 A. No.

22 Q. Okay. And lastly, we can take
23 breaks at your leisure anytime you need to.

24 A. Okay. Let me silence my phone, if
25 you don't mind.

1 Q. Sure. And the breaks, just so
2 long as there's not a pending question. So if
3 you need to take a break, let me know, then you
4 can answer the question, and we'll do that. I
5 drink a lot of liquids, so we'll take some
6 breaks. Efficient breaks.

7 Okay. What areas of expertise are
8 you qualified, in your opinion, to give expert
9 testimony?

10 A. General pediatric medicine and
11 pediatric endocrinology.

12 Q. Okay. How many depositions have
13 you given?

14 A. This would be a guess. About 15.

15 Q. Okay. And for all 15 was the
16 subject matter pediatrics or pediatric
17 endocrinology?

18 A. Yes.

19 Q. So have you ever given deposition
20 testimony where you were not serving as an
21 expert witness?

22 A. Yes.

23 Q. And what was that?

24 A. That was a malpractice case.

25 Q. Okay. You've never been involved

1 in litigation as a party; is that correct?

2 A. I was.

3 Q. Okay. Okay. And that was for the
4 malpractice?

5 A. Yes. That was a malpractice case,
6 yes.

7 Q. Okay. So for those 14 other
8 depositions, were they related to challenges to
9 laws, like actual statutory law?

10 A. No.

11 Q. Okay. Regulations or policies?

12 A. A few of them were, but most of
13 them had to do with medical expert issues
14 related to endocrinology and the practice
15 thereof.

16 Q. Okay. So in those cases about
17 pediatric endocrinology, was one party a
18 government entity in all of those cases?

19 A. No.

20 Q. Okay. In some of those cases was
21 the government a party?

22 A. I do not believe so.

23 Q. Okay. So all of the parties in
24 all these cases were private, both plaintiffs
25 and defendants?

1 A. For the medical malpractice cases,
2 but the cases where I've done depositions
3 regarding the subject of transgender health,
4 there were not governed entities involved.

5 Q. And were you in all those cases an
6 expert for the defense or for the plaintiffs?

7 A. For the defense. And I want to
8 restate my prior. This was one case in
9 Hamilton County, Ohio involving the DEFAS, or
10 the equivalent to Child Protective Services.

11 Q. Okay.

12 A. So that's one case. And there
13 were multiple plaintiffs in that case. One of
14 which was a government entity.

15 Q. Okay. So can you recall what
16 these cases were specifically?

17 A. The ones dealing with transgender
18 health specifically?

19 Q. Sure.

20 A. Okay. There were school systems
21 in British, Columbia. There was the DEFAS in
22 Ohio, in Hamilton County, Ohio. Okay. There
23 also was in North Carolina the famous Bathroom
24 Bill. I had to do an affidavit for that.

25 Q. Okay.

1 A. So that's three. Okay. Just to
2 clarify, now that I go through each one of
3 them, those were the ones that had to do with
4 government entities.

5 Q. And those were government
6 entities, all three of those?

7 A. Yes.

8 Q. Okay. But those are not the
9 extent of your deposition testimony in the
10 space of transgender issues?

11 A. No.

12 Q. What other cases have you given
13 deposition testimony in related to transgender
14 issues?

15 A. Issues of patient care.

16 Q. Okay. But what were those cases
17 specifically? Can you recall?

18 A. Let me think. I'm having
19 difficulty recalling each specific case. Given
20 some time I probably can come back and revisit
21 that question.

22 Q. Okay.

23 A. But I don't want to give an
24 improper answer.

25 Q. Okay. Perhaps we'll revisit these

1 questions when we pull out your CV later on.

2 A. Okay.

3 Q. About how many times -- oh.

4 Actually, how did you come to be involved, just
5 generally or specifically, if that's more
6 helpful for you to explain, the transgender
7 issues cases? How did you come to be an expert
8 in those cases?

9 A. From my fellowship training at
10 Johns Hopkins back in 1978 through 1980.
11 Transsexual, as it was called then, was part of
12 our curriculum in the fellowship.

13 Q. Okay.

14 A. And we had children with disorders
15 of sexual differentiation who presented at
16 Johns Hopkins, because it was sort of an
17 epicenter, if you will, for referral of those
18 patients from around the world and clearly from
19 the United States.

20 So we had a lot of patients who
21 had issues with ambiguity of genitalia or
22 medical conditions where hormones were produced
23 early or were overproduced by tumors, and they
24 looked at the behavioral aspects of the effects
25 of that and issues of their psychological

1 wellness. And so that was part of our
2 fellowship.

3 Q. Okay.

4 A. So it began then, and it laid
5 quiet for a number of years until the
6 transgender issue sort of began to surface in
7 the United States in the early 1990s. I had a
8 case, but that was a rarity. And then in the
9 early 2000s to mid 2000s, the number of
10 transgender clinics began to expand
11 exponentially, and so there was a lot more.
12 There were guidelines produced, and that
13 brought everything to the attention and sort of
14 woke up the concept. So then everyone began
15 paying attention to it, and those of us who had
16 experience prior to that began to speak out.

17 Q. Okay. So perhaps I wasn't super
18 clear. That's all helpful, and we will
19 continue to explore your expertise and
20 training. How did you come to be involved in
21 the litigation matters?

22 A. I was asked by people who were
23 involved in legal battles to be an expert
24 witness.

25 Q. Okay.

1 A. And I had actually given a
2 presentation on the subject of transgender
3 medicine and its history, and that sparked
4 people's interest in my world view on the
5 subject.

6 Q. Okay. So when people searched for
7 experts, your presence in the community was
8 easily accessible?

9 A. Yes.

10 Q. Got it. Okay. All right. How
11 many times have you given trial testimony?

12 A. I can think of two.

13 Q. Okay.

14 A. One was a case in Springfield,
15 Illinois about a malpractice case involving
16 maltreatment of a patient. It had nothing to
17 do with transgender. The other was a murder
18 case in California when I was a resident.

19 Q. And was that murder case related
20 to transgender issues at all?

21 A. No.

22 Q. Okay. And how long ago did you
23 say those were?

24 A. The murder case was in -- it's an
25 approximation -- 1975. And the malpractice

1 case in Springfield, Illinois was I believe two
2 years ago.

3 Q. Okay. You just stated previously
4 right here that you had given a presentation on
5 transgender issues, and that's how people came
6 to know your position in the community as
7 holding yourself out as an expert of sorts.
8 Can you talk a little bit about what that
9 presentation was?

10 A. It was a presentation in -- I
11 believe it was Fort Worth, Texas. It was a
12 presentation for teenagers and their families,
13 and it was one of a number of subjects
14 presented at that particular forum, and I was
15 asked to speak on the history of transgender
16 medicine.

17 Q. Okay. And about when was that?

18 A. And time goes by very fast. I'm
19 going to state, about four years ago.

20 Q. Okay. And so you said it was a
21 conference for teens and families. Was it a
22 kind of a multi-disciplinary conference? Did
23 they invite speakers besides medical doctors to
24 come and educate, or was it strictly about
25 medicine?

1 A. It was not just medicine alone.
2 It was individuals who had undergone issues in
3 their lives that they would wish to speak to
4 the teenagers about to give them personal
5 experience.

6 Q. Okay.

7 A. And then there were behavioral
8 health specialists that talked. There were
9 authors there who spoke on things that they had
10 written. Books that they had written.

11 Q. Okay. And this was in Fort Worth.
12 Do you know who invited you to speak?

13 A. The name of the conference was
14 Teens 4 Truth.

15 Q. Okay. And so Teens 4 Truth, is
16 that an organization?

17 A. I don't know. I think it was just
18 the organization of the conference. I don't
19 know that it exists as an entity.

20 Q. Okay. Teens 4 Truth. So you know
21 the name of the conference, and just an
22 individual who held themselves out as a staff
23 member for Teens 4 Truth reached out to you?

24 A. Called and said they had heard --
25 I can't remember how they heard specifically.

1 Q. Okay.

2 A. But they said, could you speak to
3 us on this subject?

4 Q. Okay. Did you attend any of the
5 other panels or presentations?

6 A. I did.

7 Q. Okay. So the behavioral health
8 specialists, what were the themes or primary
9 messages that were being conveyed by those
10 experts?

11 A. That teens have a lot of things
12 that basically weigh on them as they grow up,
13 and that the teens and the families need to
14 essentially communicate effectively and deal
15 with deep-seeded emotional problems and
16 depression and anxiety mostly.

17 Q. Okay.

18 A. And that to bury those things or
19 not talk about them or have families not
20 recognize them brings harm to those
21 individuals, and therefore there should be an
22 avenue of communication where the families
23 recognize the teens feel comfortable enough to
24 talk to their parents about these issues. And
25 so that instead of hiding them or burying them,

1 that they should deal with those, because
2 there's a great deal of suffering and agony
3 that happens as a result of that.

4 Q. Okay. Were those behavioral
5 specialists also providing information or
6 speaking on the issues of transgender issues?

7 A. I think I was the -- I think there
8 was a mention of transgender health by one of
9 the presenters, but most of them were on the
10 subjects of anxiety and depression dealing with
11 sexuality.

12 Q. Okay. So what again was the name
13 of the conference? I'm sorry.

14 A. Teens -- No. 4 -- Truth.

15 Q. Oh, okay. Perhaps if I remind
16 you, you may recall. That's a Baptist
17 anti-LGBT conference. Does that characterize
18 it accurately?

19 A. No.

20 MR. BLAKE: Objection.

21 BY MS. INGELHART:

22 Q. Okay. But is it a Baptist
23 affiliated organization?

24 MR. BLAKE: Objection.

25 THE WITNESS: I was unaware that

1 it had any religious affiliation to it.

2 BY MS. INGELHART:

3 Q. Okay. Were the topics -- you
4 said, primarily, though, they were about sexual
5 orientation and gender identity, correct?

6 MR. BLAKE: Objection.

7 THE WITNESS: Primarily about
8 depression and anxiety and how it manifests as
9 someone's developing their sexuality.

10 BY MS. INGELHART:

11 Q. Okay. And do you use the term
12 developing their sexuality to include the terms
13 like sexual orientation and gender identity or
14 specifically --

15 A. All of it. It's all inclusive.

16 Q. Okay. Were you paid to attend
17 that conference?

18 A. My air fare and my lodging was
19 taken care of, and the meals were provided. So
20 that was all.

21 Q. Okay. So there's like no
22 honorarium?

23 A. I did not receive an honorarium.

24 Q. And were you reimbursed for those
25 payments?

1 A. I was reimbursed for the air fare.
2 The lodging was paid for. It was a conference
3 site, and it was taken care of.

4 Q. Sure. Okay. So there was like an
5 exchange of repayment to you like via a check
6 or something?

7 A. I can't remember specifically.

8 Q. Okay. Okay. All right. Have you
9 ever given testimony at a legislative hearing,
10 for instance?

11 A. I do not believe I have.

12 Q. Okay. Have you ever given
13 testimony at all in a legislative setting?

14 A. Again, I don't believe I have. I
15 mean, in regard to transgender specifically. I
16 have given testimony in the Georgia State
17 Legislative Committees in hearings for issues
18 of general pediatric health.

19 Q. Got it. I was speaking generally.

20 A. Yeah. Okay.

21 Q. Thank you. Thank you for clearing
22 that up.

23 A. Yeah.

24 Q. Okay. And how did you come to
25 testify? Were you a public participant? Did

1 you seek to speak at these events?

2 A. I did. I was the Chairman of the
3 Legislative Committee of the George Chapter of
4 the American Academy of Pediatrics at the time.

5 Q. Okay. So you weren't invited to
6 speak. You affirmatively decided to go speak
7 at those?

8 A. Yes.

9 Q. Got it. Any other like government
10 related speaking engagement type events that
11 you can recall you participated in?

12 A. No.

13 Q. Okay. What about government
14 education? Perhaps an agency, like a health
15 agency, asks you to come meet with them to
16 discuss your expertise. Anything ever like
17 that?

18 A. I have been asked but unable to
19 attend because of time constraints.

20 Q. Okay. And so none of this sort of
21 government related testimony that you provided
22 has been about issues related to transgender
23 people; is that correct?

24 A. In hearings, yes. That's correct.

25 Q. Okay. Okay. Sorry. Thank you

1 for the clarification. Okay. How many times
2 have you been disclosed as an expert in
3 litigation? Do you know?

4 A. I'd have to guess.

5 Q. That's fine.

6 A. Did you say deposed?

7 Q. Disclosed?

8 A. Disclosed. Okay.

9 Q. Yeah. Thank you.

10 A. 25 times.

11 Q. Okay. And in all of those, was
12 your subject matter expertise related to
13 pediatrics or pediatric endocrinology
14 specifically?

15 A. Yes.

16 Q. Did any of those cases involve
17 trans issues?

18 A. Some of them did.

19 Q. Okay.

20 A. More recently. The ones more
21 recently.

22 Q. Okay. You said --

23 MS. INGELHART: Can you repeat
24 back? How many times has he been disclosed?
25 Apologies.

1 THE COURT REPORTER: 25.

2 MS. INGELHART: Thank you.

3 BY MS. INGELHART:

4 Q. Okay. So 25 times, but you've
5 only been deposed about 14 times. Were you
6 deposed in each of the cases related to trans
7 issues?

8 A. No.

9 Q. Okay. Do you happen to know what
10 the underlying issues were in all of those
11 matters in which you were disclosed as an
12 expert?

13 MR. BLAKE: Objection.

14 THE WITNESS: I can't remember.

15 BY MS. INGELHART:

16 Q. Okay. Do you recall whether you
17 were a witness for plaintiffs or defense across
18 those cases?

19 A. Most often, it was for the
20 plaintiffs.

21 Q. Okay.

22 A. In the malpractice cases, most
23 often those were the plaintiffs. I think I did
24 two malpractice cases where I was for the
25 defense.

1 Q. Okay. Have you been on the
2 plaintiff side in the cases where you've been
3 disclosed as an expert where transgender issues
4 are at issue?

5 A. In one case.

6 Q. What was that case?

7 A. That was the Hamilton, Ohio case.

8 Q. Got it. Okay. And then in all of
9 the other cases where you've been disclosed as
10 an expert, were you counsel for the defense in
11 all but the Hamilton case?

12 MR. BLAKE: Objection.

13 BY MS. INGELHART:

14 Q. Or not counsel. I'm sorry.
15 Expert for the defense.

16 A. I believe so.

17 Q. Okay. Thank you. How many times
18 have you executed an expert report?

19 A. Again, this is sheerly a guess,
20 because I was not prepared to have all the
21 specifics at hand. So it's coming through
22 memory. I would say a dozen times.

23 Q. Okay. So you've given expert
24 deposition testimony about 14 times but only
25 produced reports about a dozen times; is that

1 right?

2 A. That doesn't match. So it would
3 have to be at least 14 times.

4 Q. Okay. Okay. And those reports,
5 were they majority related to trans issues?

6 A. No.

7 Q. Okay. About how many of those
8 were related to trans issues?

9 A. I'm going to guess about five or
10 six.

11 Q. Okay. And the others were related
12 to what?

13 A. Just malpractice.

14 Q. Okay. All right. And in the
15 cases in which you have executed an expert
16 report that was related to trans issues, were
17 you an expert for the defense exclusively?

18 A. No. I was an expert for the
19 plaintiff in the Hamilton County case.

20 Q. Okay. And there was a report in
21 that case?

22 A. Yeah.

23 Q. Do you recall what cases you
24 executed expert reports for related to trans
25 issues?

1 A. Okay. So again I think I've
2 written this down, and I'm going to do this
3 without any papers in front of me.

4 Q. That's okay.

5 A. Hamilton County, Ohio case, the
6 North Carolina Bathroom Bill case, two cases in
7 Canada, the case Grimm Versus Gloucester County
8 in Virginia. I'm blocking on any others at the
9 moment.

10 Q. Okay. And do you know the
11 difference between an expert report and an
12 expert declaration, correct?

13 A. I'm sure I do.

14 Q. Okay. So if I were to ask you
15 whether you know how many cases you've executed
16 an expert declaration, would you be able to
17 speak to that?

18 A. No.

19 Q. Okay. So down the line we've
20 talked about trans issues related to government
21 testimony, as well as in litigation. Have you
22 ever in litigation testified or written a
23 report regarding intersex or sexuality issues?

24 A. No, I have not.

25 Q. So your expert testimony that has

1 resulted in deposition testimony or in a report
2 or a declaration has been pretty much
3 exclusively trans related as --

4 A. To clarify that. It's impossible
5 to discuss trans issues without bringing in
6 some background knowledge about disorders of
7 sexual differentiation. So DSTs. Am I -- is
8 that how you...

9 Q. That's helpful.

10 A. Okay. So they are distinct, in
11 general. So in terms of not confusing one with
12 the other, it's important, and my reports have
13 mentioned specifically disorders of sexual
14 differentiation, I believe, in almost every
15 trans case.

16 Q. Okay. And so is the only reason
17 intersex issues are included in those reports
18 in trans specific type cases about the
19 distinction, or is there another reason you --

20 A. It's about the distinction. It's
21 also about clarification of actually what is a
22 disorder of sexual differentiation, because it
23 tends to be a matter of opinion in some cases
24 in terms of the science of DSDs as they are
25 recognized by the organization. The

1 professional organization. It's one specific
2 thing, but it has been expanded quite broadly
3 by proponents who say the incidence is as high
4 as maybe one percent or .3 percent of patients
5 across the country -- or humans across the
6 country. So that's a difference of opinion.

7 Q. Okay. But I think that was about
8 intersex issues, and I think you said it's
9 impossible to do testimony about trans issues
10 without talking about intersex issues. Why is
11 it impossible?

12 A. Because it's an educational
13 process.

14 Q. Okay.

15 A. I mean the purpose of what I'm
16 trying to do is provide background in science
17 and education, so that people can make a
18 reasonable decision.

19 Q. Okay. But are they related, trans
20 issues and intersex issues?

21 A. Very rarely.

22 Q. Okay. In the case of Schneider V.
23 Lujan, you testified in deposition in that
24 case, right?

25 A. Remind me specifically where

1 that -- the name is not --

2 Q. In Okaloosa County.

3 A. In Florida. Yes, I actually -- I
4 was able to write a report.

5 Q. Okay. So you didn't give a
6 deposition?

7 A. I did not.

8 Q. Okay. And then about what did you
9 provide testimony in that case?

10 A. Just background information about
11 transgender.

12 Q. You provided testimony in the case
13 of Kimora Gilmer, correct?

14 A. Correct.

15 Q. What court was that? Do you
16 recall?

17 A. I do not.

18 Q. Okay. And what did you provide
19 testimony about there?

20 A. Again, basic information
21 background about transgender issues.

22 Q. Okay. And in the Grimm case that
23 you mentioned, your testimony was about trans
24 issues, right?

25 A. It was specifically about the fact

1 that there was -- it was related to documented
2 science that showed either benefit or lack of
3 benefit or harm based on use of rest rooms.

4 Q. Okay.

5 A. That's very specifically focused.

6 Q. Okay. Was that similar testimony
7 to what you provided in the Carncano case?

8 A. Yes.

9 Q. In North Carolina?

10 A. Yes.

11 Q. Okay. And did you provide
12 deposition testimony in either of those two
13 cases?

14 A. No. Wait a minute. Let me just
15 think back on that.

16 Q. Sure.

17 A. North Carolina, and what was the
18 other one?

19 Q. The Gavin Grimm case in the
20 Eastern District of Virginia.

21 A. Yeah. I was deposed for that,
22 yes.

23 Q. Okay. Do you recall the Cooley V
24 Paul case?

25 A. The name is not registering. I'm

1 sorry.

2 Q. Okay. What about Jessica
3 Siefert's case?

4 A. Yes.

5 Q. Where was that?

6 A. Let me think for a minute. I'm
7 forgetting exactly specifically the
8 jurisdiction.

9 Q. Do you recall what your testimony
10 was about?

11 A. It was about parents -- oh,
12 Siefert is Ohio. That's Hamilton County, Ohio.
13 Yes. Is that -- I'm remembering correctly?

14 Q. It wasn't In Re: JNS, in Hamilton
15 County, Ohio?

16 A. I don't think so.

17 Q. Okay. All right. Go ahead.

18 A. I think Siefert is Ohio.

19 Q. Okay. Can you tell me about what
20 your testimony was there?

21 A. It was giving information about
22 trans health and the concepts of affirmation
23 therapy versus counseling therapy.

24 Q. Okay. And what do you mean,
25 affirmation?

1 A. Affirmation is a term that's used
2 to do social transition, medical transition and
3 surgical transition.

4 Q. Okay. And then counseling?

5 A. Counseling was the pathway that
6 Dr. Kenneth Zucker proposed and used for about
7 30 plus years.

8 Q. Okay. And what was that?

9 A. That is basically an in-depth
10 psychological evaluation of the patient,
11 family, and ongoing counseling of the patient
12 to basically discover what's going on in terms
13 of their psychological background.

14 Q. Okay. And so in that case, where
15 you discussed the benefits and the science of
16 affirmation versus counseling, did you have
17 professional conclusions about which was the
18 better course of treatment?

19 A. Yes.

20 Q. And what was that?

21 A. Is that the counseling, which is
22 referred to as watch and wait, which there's
23 nothing just watching and waiting. It's very
24 intense and consistent. It is that there is
25 clear benefit there that those patients that go

1 through that -- this was a minor, okay, at the
2 time -- have a very high likelihood of
3 resolving their gender incongruence with the
4 benefit of counseling, appropriate counseling,
5 in-depth counseling. And that if that is the
6 case, affirmation with hormones and social
7 circumstances and then, if chosen, surgery,
8 provide far more complications for that
9 patient's life, and their quality of life that
10 is diminished significantly compared to those
11 who went through counseling alone.

12 Q. Okay. And just so I'm clear, is
13 the counseling course of treatment ever
14 colloquially referred to as conversion therapy?

15 A. It is often mislabeled as
16 conversion therapy. It is, in truth, affirming
17 one's sex, if possible. Most often it's
18 focused on the issues of depression and anxiety
19 and the childhood adverse events that created
20 the background for which set this patient up to
21 have a world view that they were born into the
22 wrong body.

23 Q. Okay. And I'm sorry. In the
24 Hamilton County case, that's juvenile court.
25 That was an issue of custody?

1 A. Custody.

2 Q. Okay. And the subject matter you
3 discussed was trans related. What specifically
4 were your conclusions in that case?

5 A. That intervention with medical
6 therapy at the time would be inappropriate
7 until the patient was of the age of consent.

8 Q. Okay. Okay. Okay. In the cases
9 where you say you simply provided background on
10 trans issues, what party hired you?

11 A. It was either the family of the
12 patient -- most often it was representing the
13 family of the patient. I can't recall
14 specifically other entities which, you know,
15 compensated me for my time. It was usually the
16 attorneys for the person who was involved. Or
17 if they were being sued, the families and the
18 entities asked me for expert opinion.

19 Q. What were the parties' position?
20 Why did they need you?

21 A. Because they needed somebody to
22 give an opinion that essentially stated that
23 the possibility of social affirmation, medical
24 affirmation and surgical affirmation was more
25 harmful than beneficial.

1 Q. Okay. So just to be clear, they
2 needed somebody to testify that affirmative
3 care treatment for trans folks to affirm the
4 trans identity of somebody was not the correct,
5 in your opinion --

6 A. That's correct.

7 MR. BLAKE: Objection.

8 BY MS. INGELHART:

9 Q. Okay. Thank you for that.
10 Without sharing any attorney work product or
11 privileged conversations what did you do to
12 prepare for today?

13 A. I read the statements that I had
14 made. I read Dr. Ettner's statement, and I
15 read Dr. Gordon's rebuttal in my statement.

16 Q. Okay. So you -- oh, sorry. Go
17 ahead.

18 A. And also there was a judgment I
19 think that was recently handed down on the
20 order regarding dismissal, and I read through
21 that.

22 Q. Okay. So you read the three
23 experts' reports in this case and the recent
24 order and opinion?

25 A. Three expert reports. It was

1 Gordon and Ettner, the two that I had.

2 Q. And didn't you say yours?

3 A. And mine. Okay. Yes.

4 Q. Okay. You didn't review anything
5 else?

6 A. There was a mention in Dr.
7 Gordon's rebuttal that one of the references
8 that I used did not support what I had said,
9 and I went back to look at that, and I had to
10 agree that the specific statistic that I had
11 quoted from that was not in that article. So I
12 must have missed references unwittingly.

13 Q. Okay So you went out and reviewed
14 that publication?

15 A. Yes.

16 Q. Got it. Okay. Who first
17 contacted you about being an expert in this
18 matter?

19 A. Mr. Blake did.

20 Q. Okay. Okay. Did you have any
21 prior interaction with Mr. Blake?

22 A. No.

23 Q. What about with the State of Ohio?

24 A. No. Well, excuse me. Hamilton
25 County, Ohio.

1 Q. Okay. So any interaction with the
2 Ohio Department of Health?

3 A. No.

4 Q. Okay.

5 A. Unless Child and Protective
6 Services is under that umbrella. I don't know
7 the spectrum.

8 Q. I also don't know.

9 A. Okay.

10 Q. Any prior relationship with the
11 law firm of Mr. Jake Blake -- Mr. Jason Blake,
12 Calfee?

13 A. No.

14 Q. Okay. When did counsel reach out
15 to you?

16 A. It was late May of this year.

17 Q. Okay. Are you being compensated
18 for rendering your opinion in this matter?

19 A. I am.

20 Q. Okay. How are you being
21 compensated?

22 A. A retainer fee of \$1,500, and then
23 review of records in preparation of records at
24 \$350 per hour. Deposition \$450 per hour,
25 unless it's out of state, where I'm out of the

1 office. So today the payment for my day's work
2 here is \$3,500.

3 Q. Got it. Okay. So you're not
4 separately being paid like by the hour for
5 deposition testimony? It's a lump sum for
6 payment?

7 A. It is a lump sum for this, yes,
8 for the deposition day.

9 Q. Thank you. Okay. Do you know
10 roughly what you've billed to date for this
11 matter?

12 A. I think it's been -- It might be
13 upwards of \$2,800. Something around that
14 amount.

15 Q. Okay.

16 A. I can look up, specifically.

17 Q. Not including today?

18 A. Not including today.

19 Q. Okay. Got it. You're being
20 offered as an expert in pediatric endocrinology
21 in this matter, correct?

22 A. That's correct.

23 Q. Do you consider yourself to be an
24 expert in gender dysphoria?

25 A. In that it is part of

1 transgenderism, and transgenderism falls on the
2 shoulders of endocrinology to provide medical
3 treatment. So we have to have a background and
4 expertise in the foundation of what is
5 transgenderism. And so for that reason,
6 literature when I research writing has been --
7 and so in that case, I would say yes.

8 Q. Okay. So you consider yourself an
9 expert in gender dysphoria. I heard you
10 mention transgender issues. So you consider
11 yourself an expert in transgender issues as
12 well?

13 A. Yes.

14 Q. And what about intersex
15 conditions?

16 A. Yes.

17 Q. Okay. What makes you an expert in
18 those issues?

19 A. Training, clinical experience and
20 active interest in research and review of
21 literature.

22 Q. Okay. So is any pediatric
23 endocrinologist who consumes literature and
24 digests it on gender dysphoria an expert in it?

25 A. Not necessarily.

1 Q. Okay. What do you consider
2 yourself to be a expert in? Anything besides
3 these things?

4 MR. BLAKE: Objection.

5 THE WITNESS: Pediatric
6 endocrinology, in general, and pediatrics as
7 well.

8 BY MS. INGELHART:

9 Q. Okay. How long have you practiced
10 as a medical physician?

11 A. I graduated from medical school in
12 1973. I finished my residency in 1976. And so
13 actually actively practicing as a licensed
14 physician from 1976 to the present.

15 Q. Okay. Have you always been
16 affiliated with like a hospital institution, or
17 have you ever been in private practice?

18 A. I was in the Navy for 20 years.
19 During which time I was affiliated with
20 academic institutions and the Navy Medical
21 Corp. Upon retirement, after a 20-year career
22 in the Navy, I went into private practice but
23 maintained academic and clinical teaching
24 positions, adjunct positions, at Emory
25 University and Morehouse College of Medicine.

1 Q. So you're currently adjunct. Is
2 that accurate?

3 A. Yes.

4 Q. And then you're in private
5 practice also now?

6 A. Yes.

7 Q. Thank you. And what areas of
8 practice have you specifically held yourself
9 out as?

10 A. Pediatric endocrinology and
11 pediatrics.

12 Q. Where did you go to school?

13 A. Medical College of Virginia, in
14 Richmond, Virginia.

15 Q. When did you graduate?

16 A. 1973.

17 Q. Did you do a residency after that
18 then?

19 A. I did.

20 Q. And where was that?

21 A. And that was at Oakland Naval
22 Hospital, internship and residency in
23 pediatrics. And then my fellowship at Johns
24 Hopkins in pediatric endocrinology from 1978 to
25 1980.

1 Q. Okay. And do you hold any other
2 certifications or -- forgive me if I'm not
3 using the accurate, you know, medical term for
4 certifications or kind of specialization --
5 official recognition?

6 A. Basically, pediatrics and
7 pediatric endocrinology certification.

8 Q. Okay. Can you please describe
9 your education or training related to gender
10 dysphoria?

11 A. So it began in the fellowship
12 years, and then the issue remained very quiet,
13 because it was not a common issue in pediatrics
14 at all. My first transgender case in 1993 or
15 '94 was a patient that came to my office. A
16 military dependent child. The sex was male.
17 He had been advised to transition to female --
18 he was 13 at the time -- by a psychiatrist in
19 Los Angeles. The family moved often, and there
20 was an opportunity for sort of a clean break in
21 friendships and what all. So the family was
22 advised to go ahead and raise this child
23 subsequently as a female, and that patient came
24 to me for hormone therapy.

25 It was sort of out of the blue. I

1 called all of the people that I knew that were
2 my mentors in pediatric endocrinology across
3 the country, in San Francisco, in Baltimore,
4 in St. Louis, and said, what is your
5 experience? What do we do with this? This is
6 not an issue that we have seen, literally,
7 since fellowship days, and we were really not
8 dealing with transgender children at that point
9 in time. The experience was with the
10 transgendered adults at Hopkins. And not
11 practicing adult endocrinology, I had
12 essentially no clinical experience in the
13 interim period.

14 Nobody could tell me what to do.
15 No one had any guidelines. Nobody had any idea
16 of what was appropriate. I was advised that I
17 needed to have an attorney devise an informed
18 consent, an assent, to cover myself for any
19 potential damage that might be done that I was
20 unaware of by doing cross-sex hormones in this
21 child. And so I launched on that with the
22 assent and consent for the parents and began
23 treating that male with estrogens.

24 Within six months, the family
25 moved again, and I referred that family to a

1 pediatric endocrinologist at the Naval and
2 Medical Center in Bethesda, Maryland, since
3 they were moving to the Washington, D.C. area,
4 and I never heard. I'm not sure the patient
5 actually ever made it there. I called the
6 person that I had referred to, and he indicated
7 he'd never seen the family. So I don't know
8 what happened.

9 Q. Okay.

10 A. But that's how rare it was to deal
11 with transgendered issues in children at that
12 time.

13 Q. And what was that time again?

14 A. 1993, 1994.

15 Q. Okay. So that's when you first
16 were reintroduced to the issue and first time
17 you had seen that since your time at Johns
18 Hopkins?

19 A. Since my fellowship. Right.

20 Q. okay. And that's a pretty long
21 span.

22 A. That's correct.

23 Q. Do you have an opinion about why
24 it was such a long span between those
25 incidents?

1 A. Because it was a very uncommon
2 condition. It was exceedingly rare.

3 Q. Okay.

4 A. In terms of reported cases and
5 people who professed to have clinical
6 experience that were available in published
7 literature.

8 Q. Okay.

9 A. And recognized by academic
10 institutions.

11 Q. And it's no longer rare?

12 A. No.

13 Q. Do you have an opinion about why
14 the incidence of transgender patients
15 presenting themselves to physicians like
16 yourself is less rare?

17 A. It is clearly my opinion. I have
18 some indirect statistics that do not show
19 causality, but the advent of the internet and
20 available information to children and the
21 advocacy of the transgender movement has made
22 it a forefront issue. The combination of those
23 two things has exponentially increased people's
24 sense that it exists and that it is a real
25 entity that is biologically based.

1 Q. And so people's awareness makes --
2 how does that awareness affect the rate of
3 incidence?

4 A. The study that was published by
5 Lisa Littman showed there was sort of a social
6 contagion among adolescent females
7 particularly. The ratio of incidence from
8 twice as many males as females in the
9 background for any number of years, from
10 published studies back in the 1970s, '80s, and
11 '90s and even in the early 2000s, to the point
12 where it is now twice as many females as males,
13 and the age of onset in these females is mid
14 adolescence.

15 Q. Okay. So what I heard you say was
16 that there's a social contagion. What is the
17 social contagion?

18 MR. BLAKE: Objection.

19 THE WITNESS: The presence on the
20 internet of YouTube videos, suggestions of what
21 to say to your physician, helpful guidelines --
22 hopefully helpful -- to guide patients who have
23 issues toward the idea that they are
24 transgender.

25 BY MS. INGELHART:

1 Q. Okay. How is that a contagion? I
2 don't think I understand your use of that term.

3 MR. BLAKE: Objection.

4 THE WITNESS: It is the increase
5 cannot be explained by purely social
6 acceptance. Okay? The sociologists who have
7 reviewed this in the UK, particularly in the
8 Scandinavian, can't explain a hundred fold
9 increase in the incidence of transgenderism
10 since 2010.

11 BY MS. INGELHART:

12 Q. Okay. So you're saying that the
13 cultural acceptance of trans folks does not
14 explain?

15 A. It does not explain that.

16 Q. Okay.

17 A. I'm not a sociologist, but the
18 sociologists who are trying to figure this out
19 have explained that they are quite alarmed by
20 this and in their world view as sociologists
21 can't explain that it is purely acceptance that
22 brought this about.

23 Q. And who are those sociologists?

24 A. People who publish. I don't know
25 the names specifically.

1 Q. Okay. And so for the cause and
2 effect, if the effect is that there's a higher
3 rate now, what are you saying is the cause
4 then?

5 MR. BLAKE: Objection.

6 Answer if you know.

7 THE WITNESS: It's sort of a
8 recruiting of patients online.

9 BY MS. INGELHART:

10 Q. Okay. And who's recruiting?

11 MR. BLAKE: Objection.

12 Answer if you know.

13 THE WITNESS: The nature of what
14 is online when you Google transgender is
15 explaining that transgenderism is a biologic
16 entity, that if you are concerned and upset
17 about any issues at all, consider this as a
18 option and come see us, and go to this website,
19 and tell your doctor this, and it's -- those
20 kinds of websites exist.

21 BY MS. INGELHART:

22 Q. Okay. Okay. So I apologize.
23 Could you just explain to me your understanding
24 of the word recruitment?

25 MR. BLAKE: Objection.

1 THE WITNESS: It's sort of an
2 enticement, if you will, to consider
3 transgenderism as the answer to what they're
4 feeling about their lives.

5 BY MS. INGELHART:

6 Q. Okay. Doesn't recruitment kind
7 of, again -- active -- activity or an active
8 choice or an action?

9 MR. BLAKE: Objection.

10 THE WITNESS: If someone publishes
11 something on the internet that says, this is
12 the answer, read this list, come here, call
13 these people, go to this clinic, I would call
14 that recruitment. That's an active -- somebody
15 has to go to that site, somebody has to be
16 interested in it to read it, but if you will,
17 they're not -- no, they're not doing telephone
18 robo calls and saying.

19 I guess if you're using the word
20 recruitment that way, no, it's not happening.
21 But if you have access to the internet and you
22 type in a word and you get to a website that it
23 encourages you to consider that as an option,
24 perhaps recruitment isn't the right -- but
25 encouragement. Let's call it encouragement

1 then.

2 BY MS. INGELHART:

3 Q. Okay. And those websites are
4 being created by entities. Is that what you
5 meant by the transgender movement? Are they
6 creating these platforms?

7 A. I don't know who creates them.
8 Some of them are created individually, and
9 they're personal things. Personal stories, if
10 you will.

11 Q. Okay. But previously you talked
12 about the transgender movement and recruitment.
13 So is that --

14 A. The transgender movement, I'm
15 referring to W-Path as an entity, because it is
16 an organization that is a social advocacy
17 organization.

18 Q. Okay. During your fellowship --
19 your fellowship was on pediatric endocrinology
20 at Johns Hopkins, correct?

21 A. Correct.

22 Q. Okay. And I think you mentioned
23 before that you didn't actually treat any
24 children who had had transsexualism as it was
25 called at the time or gender disorder as we

1 call it now?

2 A. Yes. Those patients were not
3 recognized as existing in the world of academic
4 medicine and publication in the academic
5 institutions. It was not part of a fellowship
6 training. We touched on that, because the
7 adult endocrine service at Johns Hopkins
8 refused to work with the adult patients who
9 were transsexual, and professor John Money who
10 was on the faculty and taught us basically
11 introduced -- we had to deal with those
12 patients. Adult endocrinologists would not
13 deal with those patients. So their hormone
14 therapies, their medical follow-up, was done by
15 the pediatric endocrine division.

16 Q. So you treated those patients?

17 A. We treated them in the sense that
18 we had to review their cases and be part of it,
19 but we did not do primary interviews. We did
20 not recommend the surgeries. All that was sort
21 of done through the psycho hormonal division
22 and John Money.

23 Q. So what was your treatment? I'm
24 sorry.

25 A. We had to follow those patients.

1 We had to examine those patients. We had to
2 talk about, you know, their medical conditions.

3 Q. Okay.

4 A. And it was new enough and without
5 any essential checklist of what to be watching
6 for, it was sort of experiential. Things were
7 done. What did we see?

8 Q. Okay. So you didn't actually
9 provide any treatment for people with
10 transsexual gender identity disorder or gender
11 dysphoria during your fellowship, correct?

12 MR. BLAKE: Objection.

13 THE WITNESS: It was done by
14 attendings, and we were, as fellows, observers.
15 BY MS. INGELHART:

16 Q. Okay. So you, personally, did
17 not?

18 A. I did not.

19 Q. Okay. In your report you mention
20 that you had, quote, an above average exposure
21 to children with disorders of sexual
22 differentiation. What do you mean by above
23 average exposure to?

24 A. Because of the sheer number of
25 patients that were referred to Johns Hopkins,

1 that fellowship program had larger numbers of
2 children with DSTs than other endocrine
3 programs have. In University of California San
4 Francisco and in other programs that were not
5 sort of the epicenters, you would see disorders
6 that were much milder. Kids with adrenal
7 hyperplasia, who were virilized, females that
8 were virilized or males that were
9 undervirilized. But most often the ones that
10 required any kind of surgical intervention that
11 was going to be considered in young childhood,
12 all of them, you know, they sort of funneled
13 towards Johns Hopkins.

14 I think Cornell Hospital Children
15 Services had a number of patients above the
16 average of other centers, as well, at the time.
17 But Hopkins was sort of -- it's where all of
18 the pathways of hormonal actions were actually
19 discovered in the lab, and so because of that
20 it was sort of the epicenter of referrals.

21 Q. Okay. So at the epicenter, about
22 how many children were you exposed to?

23 A. In the fellowship years, easily a
24 hundred.

25 Q. Okay. Again, what was the actual

1 nature of the exposure?

2 A. Direct patient care. Evaluation
3 and direct patient care.

4 Q. So treatment?

5 A. Yes. Treatment. Absolutely.

6 Q. Okay. What kind of treatment did
7 you provide to those patients?

8 A. We provided hormonal replacement
9 therapy for those where it was appropriate to
10 solve the problem. We treated some kids who
11 were boys who were undervirilized with
12 testosterone, with human chorionic
13 gonadotropin, in order to diagnose what was
14 going on and also begin some initial
15 treatments. The urologists and the GYN
16 surgeons did surgical revisions on those
17 patients. We did not.

18 Q. Okay.

19 A. But we worked hand in hand with
20 them to know the complications of the surgeries
21 and what needed to be done for surgical
22 follow-up. So all of that was done as sort of
23 a conjoined clinic.

24 Q. Okay. So were any of the children
25 that you treated for their DSD also

1 transgender?

2 A. No.

3 Q. Have you been certified by the
4 World Professional Associates of Transgender
5 Health, WPATH?

6 A. No.

7 Q. Okay. You've never completed any
8 course work with WPATH initiative committee,
9 right?

10 A. No.

11 Q. Are you familiar with it?

12 A. I was not familiar with any
13 certification whatsoever.

14 Q. Okay. Are you familiar with the
15 WPATH's standards of care?

16 A. Yes.

17 Q. And do you disagree with them?

18 A. I do.

19 Q. Would you like to share what you
20 disagree with?

21 A. Well, currently, the iteration is
22 the seventh version of their standards of care
23 and the eighth version is coming out, I
24 understand. We don't know -- it's supposed to
25 be in January perhaps. The recommendation for

1 puberty blocking at early age, at the onset of
2 puberty, the recommendation of cross-sex
3 hormone therapy, is counter to the proven
4 science of the adverse effects of those
5 entities as use, and the recommendation for
6 surgery. This is all related to children in
7 particular.

8 Q. Okay. And so the basis for your
9 opinion there is what again?

10 A. Is that the current medical
11 literature calls into question the safety of
12 and the efficacy of those interventions.

13 Q. And what medical literature?
14 Could you be more specific?

15 A. The very comprehensive article by
16 Lawrence Mayer and Paul McHugh, which is
17 probably the preeminent, most thorough, highly
18 referenced, cross referenced, balance
19 presentation of the issue of transgender health
20 that's ever been published.

21 Q. Okay. Have you made any public
22 comments to voice your disagreement with the
23 WPATH standards of care?

24 A. Yes, I have.

25 Q. Okay. In what context were those

1 public comments?

2 A. They were in court CME courses.
3 They were in interviews for publication, print
4 publication, and also radio interviews as well.

5 Q. Okay. Were those public comments
6 in your personal capacity?

7 A. Yes.

8 Q. Or like your personal/professional
9 capacity?

10 A. Yes.

11 Q. Okay. Not on behalf of another
12 organization?

13 A. No.

14 Q. Okay. Have you had any other
15 training since your fellowship ended in 1980?

16 A. Ongoing CME.

17 Q. Any training in psychiatry?

18 A. Not psychiatry, specifically. The
19 behavioral health as it relates to general
20 pediatrics and specifically as it relates to
21 pediatric endocrinology. Depression is a very,
22 very prominent entity in Type 1 diabetes
23 patients. It's clearly an entity in patients
24 who have disorders of sexual differentiation.
25 It's a large part of anything that requires

1 compliance. Any kind of disorder which is not
2 going away, it impinges on the mental health of
3 the patient. And so we are always reminded and
4 trained to recognize depression and anxiety and
5 social interactions of these patients with
6 their peers, with their family and educational
7 environment.

8 Q. Okay.

9 A. So it's part of our everyday
10 evaluation of every endocrine patient that
11 comes into the office. If you have
12 particularly issues with poor growth, delayed
13 puberty, those issues are very, very important
14 to pay attention to. We were trained that it's
15 basically a basic tenet of pediatric
16 endocrinology. Anything that affects self
17 image is going to need to be paid attention to.
18 So every endocrine visit in the office for
19 whatever purpose the patient's there, we always
20 ask the issues about depression, anxiety,
21 school performance, interaction with peers.

22 Q. Okay.

23 A. As an assessment for, you know,
24 how they're doing.

25 Q. So that was training from the

1 beginning on through your --

2 A. On -- the beginning ongoing, yes.

3 Q. Okay. Do you hold yourself out as
4 an expert in psychiatry?

5 A. No, I do not.

6 Q. Okay. Do you have any training in
7 psychology beyond what we just discussed?

8 A. No.

9 Q. And do you hold yourself out as an
10 expert in psychology?

11 A. As it relates to illness, in terms
12 of behavioral health, yes. Not as a licensed
13 physiologist.

14 Q. Okay. Sorry. I couldn't read my
15 own writing. So that experience at Hopkins, is
16 that the foundation of your expertise in issues
17 relating to sex differentiation as it relates
18 to gender identity?

19 A. It was the beginning of that, yes.

20 Q. Does board certification in
21 pediatrics require any course work on gender
22 dysphoria?

23 A. It has not, because it's not been
24 part of a curriculum. They're trying to
25 develop some curriculum. I understand it's in

1 several medical schools, but it's not been part
2 of medical education specifically.

3 Q. Okay. And I think you mentioned
4 this. You're required to complete continuing
5 medical education courses to maintain your
6 Georgia license?

7 A. That's correct.

8 Q. Okay. Are any of those courses
9 required courses on trans related issues?

10 A. No.

11 Q. What about intersex related
12 issues?

13 A. Not specifically requested.

14 Q. Okay. Or gender issues at all?

15 A. Nothing is required specifically.

16 Q. Okay. But are there courses
17 offered on trans issues that you could take as
18 a part of your continuing medical education?

19 A. There were CME presentations, but
20 unfortunately they're -- the few that I've
21 attended have not been really educational.
22 They're just sort of opinion pieces, if you
23 will, and it's sort of a certain reliable group
24 of individuals who are invited to speak and
25 only those individuals and no one else at major

1 CME conferences with professional societies is
2 invited or allowed to speak.

3 Q. So you have, though, attended some
4 continuing medical education courses that
5 relate to trans issues?

6 A. Yes, I have.

7 Q. Okay. They just weren't required?

8 A. They were not required.

9 Q. Got it. Okay. What about have
10 you attended continuing education on intersex
11 issues?

12 A. Yes, I have.

13 Q. Okay. And gender issues,
14 generally, as well?

15 A. Yes, I have.

16 Q. Okay. And you received credit for
17 all of those?

18 A. I did.

19 Q. Okay. Okay. I think you said
20 here today and in your report that you've
21 maintained a continued interest in gender
22 discordance since your fellowship and have read
23 extensively the literature in scientific peer
24 reviewed journals, have attended national and
25 international pediatric endocrine conferences

1 where the subjects presented and discussed.

2 Why did you have that continued interest in
3 gender discordance after your fellowship ended?

4 MR. BLAKE: Objection. Go ahead.

5 THE WITNESS: Because of what I
6 knew about valid science, I was quite concerned
7 that invalid science was being represented by
8 the individuals presenting on the side of
9 affirmation therapies. And I decided that was
10 something that if I was going to pick a
11 subject -- there's so many subjects in medicine
12 where there are controversies, but this I saw
13 as a really significant harm to children.

14 And because of my compassion and
15 care for kids, in general, this was an area
16 where my colleagues, when I would have
17 discussions -- who had no clinical experience
18 whatsoever -- had just essentially accepted
19 guidelines that I knew, and I had actually,
20 when the endocrine society guidelines were
21 proposed, we were invited to comment on them.

22 And the comments that I made for
23 both the first iteration of the Endocrine
24 Society and guidelines and the second and also
25 the comments that I made about the Pediatric

1 Endocrine Society guidelines as they were
2 presented -- because we had as members an
3 opportunity to comment on those cases --
4 nothing that I said was ever responded to, and
5 I was somewhat taken aback and surprised that I
6 didn't receive any kind of affirmation that I
7 had even sent in an opinion.

8 And what came out was essentially
9 everything that I was critical of just was
10 passed through and accepted as the guidelines,
11 and that particularly hit a chord with me that
12 this is an area, if I'm going to focus my
13 energies at my age on something, I can either
14 be angry about dishonesty as I see it, my
15 personal opinion in presenting pseudo science,
16 as I would call it, on perhaps 10 or 15
17 different subjects and not be effective with
18 any of them.

19 BY MS. INGELHART:

20 Q. Okay.

21 A. And so I've always been an
22 advocate of child development and emotional
23 health. In 1994 I wrote a set of guidelines
24 for the State of Georgia called the Children's
25 Agenda, in which I presented this as an entity

1 for the American Academy of Pediatrics to use
2 as a sort of, if you will, a Bill of Rights for
3 children. So that it could be presented to
4 state legislators at the beginning of their
5 legislative session, much like Japan has such a
6 Bill of Rights for children, if you will.

7 And that any legislative effort
8 that would be carried out in the state had to
9 go back to this if you want to think of it as a
10 Bill of Rights for kids, and make sure that any
11 legislative effort that they proposed was not
12 contrary to that, for that set of rights.

13 And so I wrote this for the State
14 of Georgia as a project, and it was
15 comprehensive. It had to do everything with
16 education. It had to do with accessibility to
17 health care, support of family structure, the
18 right of the family and the responsibilities of
19 the family. All these things. And I presented
20 it to the American Academy of Pediatrics, and
21 it was soundly defeated in committee. They
22 wouldn't even bring it to the floor as a
23 proposal, and that shocked me. I was really
24 upset, and I went to the people in the
25 administrative part of the American Academy of

1 Pediatrics and said, what happened?

2 And one of the more senior
3 individuals in the AAP said to me, it's a hot
4 button issue here. We cannot make statements
5 about what is best for children here, because
6 it's going to offend certain individuals. It
7 will offend single moms. It will offend same
8 sex individuals. It will affect adoptive
9 parents of any kind, and so we can't offend
10 anybody. So we're not going to make -- we
11 can't make this statement.

12 And I said, you know the social
13 science is clear about the benefits, the clear
14 advantage of a child growing up in society in
15 an intact family where the child was conceived
16 by consent of both parents, and those parents
17 have a commitment to that child until that
18 child takes its last breath. And social
19 science says that child, a child in those
20 circumstances, has higher education, less drug
21 abuse, alcohol abuse, you know, criminal
22 behavior, et cetera, et cetera, hands down, but
23 we can't say that.

24 Q. And what society was that for?

25 A. American Academy of Pediatrics.

1 Q. Okay. One second. Okay. And
2 when was that presentation you gave?

3 A. 1994.

4 Q. 1994?

5 A. Mm-hmm.

6 Q. Okay. And they said that they
7 couldn't make a statement?

8 A. They refused to endorse it.

9 (Thereupon, Plaintiffs' Exhibit 1,
10 Ensuring Comprehensive Care and Support for
11 Transgender and Gender-Diverse Children and
12 Adolescents, was marked for identification
13 purposes.)

14 BY MS. INGELHART:

15 Q. Okay. So I'm going to introduce
16 to you Plaintiffs' Exhibit 1, and I have copies
17 for everyone. Okay. So do you recognize this
18 document here?

19 A. I do.

20 Q. Can you tell me what it is?

21 A. It is a policy statement written
22 by Jason Rafferty.

23 Q. On behalf of whom?

24 A. On behalf of the American Academy
25 of Pediatrics.

1 Q. Okay. Can we turn to Page No. 4
2 here?

3 A. Mm-hmm.

4 Q. Do you see the section in the top
5 left starting with the bold heading,
6 gender-affirmative care?

7 A. Yes.

8 Q. Okay. Can you read for us that
9 first sentence?

10 A. In gender-affirmative care model
11 (GACM), pediatric providers offer
12 developmentally appropriate care that is
13 oriented toward understanding and appreciating
14 the youth's gender experience. A strong,
15 nonjudgmental partnership with youth and their
16 families can facilitate exploration of
17 complicated emotions and gender-diverse
18 expressions while allowing questions and
19 concerns to be raised in a supportive
20 environment.

21 Q. Okay. And so just real quick, to
22 turn back to the first page, can you read this?
23 Let's see. Yeah, this top line on the first
24 page that begins about policy statement.

25 A. Policy statement organizational

1 principles to guide and define the child health
2 care system and/or improve the health of
3 children.

4 Q. Okay. I remember you said this
5 was from the American Academy of Pediatrics.

6 A. That's correct.

7 Q. So this is a policy statement of
8 the American Academy of Pediatrics?

9 A. It is.

10 Q. Okay. And so we've just reviewed
11 that in their policy statement they endorse the
12 gender affirmative care model?

13 A. They certainly do.

14 Q. Okay. And so below where you just
15 read, the AAP highlights some primary messages
16 that are conveyed through GACM. Can you review
17 the first bullet point there?

18 A. Yeah. Transgender identities and
19 diverse gender expressions do not constitute a
20 mental disorder.

21 Q. Okay. And then -- okay. You know
22 what, we'll come back to this.

23 So do you have any reason to
24 believe that the policy proposal that you
25 submitted that went nowhere wasn't reviewed by

1 all of your colleagues or by the AAP?

2 MR. BLAKE: Objection.

3 THE WITNESS: It was reviewed by a
4 subcommittee before it was presented to what
5 was called the Chapter Chairman's Forum. These
6 are opportunities for membership and state
7 chapters, and the Georgia State Chapter
8 sponsored this on my behalf to present an idea
9 for the academy to consider as a policy
10 statement. So it was rejected in committee
11 before it ever got to a vote, and there is a
12 vote taken among what was then called the
13 Chapter Chairman's Forum. And it never got to
14 that stage because the committee decided to nix
15 it before it could get to the floor.

16 BY MS. INGELHART:

17 Q. Okay. But the American Academy of
18 Pediatrics has this policy in place for
19 considering policy statements, correct?

20 A. They develop policy statements by
21 getting an interested committee together, and
22 they make policy statements based on people who
23 are invited to give their opinion.

24 Q. And that procedure is not
25 necessarily flawed, is it?

1 A. It's terribly flawed.

2 Q. Okay.

3 A. A review of the policy statements
4 of the American Academy of Pediatrics was done
5 and published in the Journal of Pediatrics. I
6 don't have the exact reference, but it's been
7 within about -- I'm remembering within the past
8 10 years. It said that the development of the
9 policy statements is flawed in the majority of
10 the policy statements. It's the American
11 Academy of Pediatrics criticizing itself about
12 its development of policy statements.

13 Q. Interesting. Okay.

14 A. This particular policy statement
15 was critiqued by a clinical psychologist last
16 name of Cox, and he published his critical
17 analysis of this evaluation and indicated that
18 it was flawed to the point where many of the
19 references that Dr. Rafferty used to make
20 statements that supported what he was saying
21 actually said exactly the opposite and did not
22 support them at all. This is an independent.
23 This was not asked for. It was just published
24 very quickly after this, and this was an
25 individual who'd come to this, went through

1 every reference in here and essentially said
2 this is an embarrassment.

3 Q. And when was that?

4 A. This was within the last year,
5 because this was published initially in
6 September, and within a month of its
7 publication, a month or two, Dr. Cox came out
8 and published a rebuttal to this and said this
9 is a travesty.

10 Q. Okay. So in your children's
11 agenda that you proposed to the committee in
12 Georgia that you tried to introduce, what
13 rights did it provide for children
14 specifically?

15 A. It said the children need to --
16 should have the opportunity for education to
17 their full extent to be educated, that their
18 education should be tailored to their specific
19 needs and abilities, that they should have food
20 and shelter. They should have a family unit to
21 support them and unconditionally provide care
22 for them throughout their entire life, that
23 ideally the children should be -- this is an
24 ideal. This is not condemning anybody who
25 doesn't do this, but it is for the purpose of

1 saying if you are going to pass legislation
2 that in any way promotes things that will
3 inherently prevent these opportunities, you
4 should not pass that legislation. So it was
5 not condemnation of anything, but it was sort
6 of a golden ideal.

7 Again, a child should be conceived
8 purposely. And it doesn't happen. This is
9 real life. Okay?

10 Q. Mm-hmm.

11 A. But the reality is if you want to
12 give the best opportunity, a couple in a
13 committed, functional relationship, should want
14 a child, conceive the child, take care of that
15 child from birth until that child's death. If
16 they pre-decease the child, obviously, that's
17 not going to happen.

18 And the elements that were
19 important for that child were to be educated,
20 fed, clothed, and not emotionally abused.

21 Q. Okay. So it was a part of your
22 advocacy in this children's rights document
23 that different sex parents are preferred?

24 MR. BLAKE: Objection.

25 THE WITNESS: An intact biological

1 family. And I didn't condemn adoption. Our
2 oldest child's adopted. Adoption is a very
3 complex issue. Even under the best of
4 circumstances, where parents are loving the
5 child, providing no intended negative
6 consequences of child rearing, that child still
7 grows up, as we have learned from our
8 daughter's experience and her networking with
9 other adopted adolescents and adults in her
10 life, it is a burden. It's a burden for the
11 child who's adopted. Some of them handle the
12 burden seemingly effortlessly, but many suffer
13 quietly and live with that and have to work
14 through all the issues.

15 So it's not ideal to be adopted
16 and be raised. It's ideal to be conceived and
17 reared by your biologic parents. It's just
18 sociologically it's the best outcome. It's not
19 to say that anything that happens that's not in
20 those guidelines is intended harm. It's just
21 that's the perfect thing. Make sure that what
22 we do is in every circumstance where we have
23 control we don't do something that adds another
24 burden to the child in the child's life. We
25 don't provide them education. We don't provide

1 them adequate nutrition. We don't provide them
2 sound parenting in a family that's not
3 psychologically detrimental. All those things
4 are important to avoid happening, if you can.

5 So in the sense of, you know, it's
6 all about what is absolutely the best
7 circumstance for the child? What is the best
8 circumstance? And we know what that is.

9 BY MS. INGELHART:

10 Q. So those guidelines, based on
11 those themes and principles, rearing a child by
12 same sex parents would not qualify or would
13 increase burdens on the children?

14 MR. BLAKE: Objection.

15 THE WITNESS: There are published
16 studies which show adverse outcomes.

17 BY MS. INGELHART:

18 Q. Have you read any studies that
19 there are not adverse outcomes?

20 A. I've read reports. Yes, I have.

21 Q. Okay.

22 A. They're not validated studies.

23 They are individual case studies. Not
24 cross-sectional. The big studies that
25 essentially take the general population without

1 a recruitment of population. It's a review of
2 existing data without asking patients to come
3 and present ideas to you. The only studies
4 done like that, the published studies show that
5 there are decreased rates of education, higher
6 increased drug abuse, sexual abuse, et cetera,
7 et cetera, in the lives of those patients.

8 Q. And you've read the entire defend
9 of pot body of that research?

10 MR. BLAKE: Objection.

11 THE WITNESS: No, I have not.

12 MS. INGELHART: Okay.

13 THE WITNESS: I have not read the
14 entire body.

15 BY MS. INGELHART:

16 Q. Okay. But for the ones that you
17 disagree with, you disagree with based on
18 methodology?

19 A. Yes.

20 Q. Okay. So how do you keep up with
21 the scientific literature on gender dysphoria?

22 A. I read everything that is
23 published that I can find, and there is ample
24 opportunity to read the broad spectrum of
25 opinions, not just what -- I read everything

1 that I can find that comes across,
2 predominantly on the internet. It's an access
3 way to get printed literature, public
4 discussions, synopses of presentations. So I
5 read everything. If the word transgender is in
6 it, I read it.

7 Q. Okay. So about how many articles
8 then would you say you read per week?

9 A. Five or ten.

10 Q. Okay. So per month?

11 A. Times four.

12 Q. Okay. All right. And since about
13 five years ago, you've been keeping up with
14 this practice?

15 A. Since 19 -- 2004, actually. 2004,
16 it's very interesting, because there was what
17 we call a throwaway journal called,
18 Contemporary Pediatrics, a cover story about
19 transgender. It was out of the Boston service.
20 This was before they had really established
21 their transgender clinic officially, which Dr.
22 Norman Spack did in 2007, I believe, and it was
23 an article written that basically said this is
24 the new new. This is transgenderism. This is
25 what these children need.

1 And it caught my attention,
2 because I happened to know one of the authors.
3 Actually, the lead author. She was a fellow
4 staff pediatrician in the Navy. So I said, oh,
5 there she is. And I read through and I
6 thought, wait a minute. Where is the science
7 here? Where are you speaking from?

8 Now, I've never had a conversation
9 with her subsequently. Something that's on my
10 to do list, if I can get some time, and I don't
11 know that she's still in Boston or not. But
12 that caught my eye, and it was sort of at that
13 point in time I thought, wait a minute. How is
14 this brought up as a standard issue describing
15 many children when we're not seeing those? I
16 mean the endocrinologists don't see this. We
17 don't see this at all. This is in a pediatric
18 journal, not an endocrine publication. Where
19 is this coming from? How did that happen?

20 And then subsequently Dr. Spack,
21 from Boston, presented at the combined
22 Pediatric Endocrine Society/European Society
23 for Pediatric endocrinology meeting in New
24 York. I can't specifically remember the exact
25 year, but it was soon after that, and he gave a

1 plenary session for CME, and I sat in the back
2 of the room, and my jaw dropped, because I was
3 hearing things that were contrary to what we
4 knew. And so I said, I'm interested in this.
5 This has piqued my curiosity.

6 And so at that point in time I
7 began to saying, what is he talking about?
8 What's his experience? And it was at that
9 meeting entirely anecdotal. There was no
10 published research. He did refer to the Dutch
11 study, the Dutch protocol, which had been
12 started in early 2000 in the Netherlands, and I
13 read that and I said, well, wait a minute, wait
14 a minute, wait a minute. They're talking about
15 the few kids who fail the intensive
16 psychological background, and they talked about
17 the desistance, if you will, in gender identity
18 disorder, as it was called by Dr. Zucker at
19 that time and referred to as GID by Dr. Spack
20 and others who were members of WPATH.

21 And I thought, wait a minute. You
22 didn't even bring up the psychological
23 evaluation. You just went from, hi, I'm
24 transgender, to now we do social transition and
25 medical transition. And you skipped the big

1 issue, which is the evaluation. The in-depth
2 evaluation of the child and the in-depth
3 continuous treatment of the child and their
4 family. You skipped by that, and you went
5 right to social affirmation and on to medical
6 treatment. Why did you do that? How did that
7 happen?

8 I've never spoken to Dr. Spack.
9 I've never had a conversation, never
10 communicated directly by writing or phone or
11 anything. I was just flabbergasted that at a
12 preeminent meeting of world -- you know,
13 endocrine consortium that he presented that,
14 and there was no questioning. No questioning
15 at all.

16 And I'm not very confrontational.
17 I'll be very honest. In the back of the room,
18 as I sat there, I was more in a state of shock
19 than I was to raise my hand and say, excuse me,
20 Dr. Spack, but where did you get this
21 information? How can you state what you're
22 stating?

23 And he reminded me very much of
24 Dr. John Money, who did exactly that kind of
25 thing. I had an idea. This is what I'm going

1 to do, and we're going to see what happens.

2 Q. Okay. So about 10 years ago you
3 started keeping up with the literature in a
4 very dedicated fashion.

5 MR. BLAKE: Objection.

6 BY MS. INGELHART:

7 Q. Does any of that literature affect
8 your treatment of your patients?

9 A. My review of the literature keeps
10 essentially reconfirming my concerns about not
11 doing harm to children. Above all, not doing
12 harm and having total compassion for these
13 kids, and the more I read about how what I'm
14 doing is supposed to be harmful, I'm very, very
15 cognizant of the fact that when the patient
16 that I treat walks in the room and I state to
17 them empirically at the very beginning and
18 throughout, I am your advocate. I am looking
19 for your welfare, and I will not let go of you
20 throughout this whole process. You may have
21 concerns. I'm not judging you for anything,
22 but I am trying to gather information and
23 present to you what I believe is valid science,
24 so that you can understand it, and you can make
25 an appropriate decision.

1 And I tell them that I,
2 personally, cannot in good faith give them
3 hormone therapy that blocks puberty or that
4 physically changes them, because I would be
5 doing them harm, and that is medical
6 malpractice, and I can't do that to them. I
7 just cannot do that. So that I will do
8 everything in my power to find the counseling,
9 to make sure the evaluation is done first.

10 And what happens in my own
11 personal experience in the transgender
12 patients, who are already filtered, okay --
13 people know who I am. So if they come to my
14 office, they either are aware of my opinion or
15 they aren't, and so they've come to me to
16 basically treat their child or to get a
17 treatment plan. So I don't have hundreds of
18 patients. Okay? And so the ones that I do
19 have absolutely unequivocally 100 percent of
20 them come from dysfunctional families and have
21 had a number of adverse childhood events in
22 their lifetime. Death of a parent, sexual
23 abuse, death of a sibling, severe physical
24 trauma, multiple moves, and they are
25 significantly depressed and have anxiety. And

1 that's the basis from which I start is to say,
2 we need to find a therapist who can deal with
3 all these emotional turmoils. We need to have
4 a therapist who's willing to work with all
5 members of the family and interview them
6 extensively and figure out what the dynamics
7 are, the psychological dynamis of that child's
8 environment. And if we don't do that, we are
9 doing an intense disservice to the child.

10 Q. Okay. So what you were just
11 referring to about the evaluation and patients
12 coming to you seeking hormones, was all of
13 that and subsequent about specifically children
14 patients who present or think that they have
15 gender dysphoria?

16 A. Yes.

17 Q. Okay. How many patients like that
18 have you had?

19 A. 15.

20 Q. Oh. 15?

21 A. Mm-hmm.

22 Q. Okay. This year?

23 A. No, no. There are 15 active
24 patients so far that have been recruited over
25 the past three or four years.

1 Q. Okay. So 15 active patients, and
2 active means you still currently have a
3 relationship?

4 A. Yes.

5 Q. Okay. That's all of the children
6 who have come to you presenting this kind of
7 issue where they want hormone treatment?

8 MR. BLAKE: Objection.

9 THE WITNESS: They come in with a
10 diagnosis of gender incongruence.

11 BY MS. INGELHART:

12 Q. Okay. And they come in to you.
13 They're recruited, you said?

14 A. No.

15 Q. Okay.

16 A. The patients, they just call the
17 office and say, I need to make an appointment.

18 Q. Okay.

19 A. Some of them are referred by their
20 primary care physicians.

21 Q. Okay. 15 active. Were there any
22 before that?

23 A. No.

24 Q. Okay. When did the first of those
25 15 come to your office?

1 A. Three or four years ago.

2 Q. Okay. Thank you. Do these
3 children have other pediatric endocrine issues,
4 so that they remain in your treatment?

5 A. The most recent one did.

6 Q. Okay. But there's 15 active?

7 A. Yeah.

8 Q. And so what treatment are you
9 providing to those 14 that don't have other
10 endocrine issues?

11 A. Supportive education, evaluation
12 of all of their physical complaints that are
13 related. And even non-endocrine, because I'm
14 at heart a pediatrician. So I recognize, you
15 know, other system complaints that need
16 attention as well and sort of educate them on
17 those things without stepping on the toes of
18 the primary care physician in offering specific
19 treatment. At least I give them a
20 comprehensive world view of everything about
21 them that I can glean from their history and
22 physical exam. And then I maintain support of
23 the family and the child to keep in touch and
24 make sure that I'm having conversations with
25 their mental health care providers.

1 Q. Okay. So you have an intake
2 appointment?

3 A. Yes.

4 Q. Okay. And then after that?

5 A. The intake is staged, so that
6 initially the first appointment is a thorough
7 physical exam and a total review of medical
8 history, and then it is sort of focusing on
9 their specific complaint about transgender
10 issues. I interview the child and the family
11 all together. I find out what kind of mental
12 health support they're using and who that
13 person is. If they haven't had any, then I
14 suggest like through their primary care a
15 general behavioral health person, because
16 that's a very difficult choice. It has to be a
17 good fit. It has to be somebody personality
18 wise. It has to be somebody you know doesn't
19 have an agenda up front, that's not a
20 transgender specialist. There is no such
21 reality of somebody who is not an activist, who
22 just does transgender health only, in terms of
23 mental health. If they advertise that as
24 colleagues I interviewed and talked to, say
25 I've been doing this for 37 years in treating

1 transgender health in Atlanta, I sort of
2 question them and say, okay, what else do you
3 do? And they often do nothing but transgender
4 health issues.

5 Transgender is a psychological
6 issue at its core, and you don't have to be
7 trained in transgender only issues. You need
8 to recognize the world's literature in
9 transgender, but you need to be able to
10 recognize depression, anxiety and delve into
11 the adverse childhood events. And if you can't
12 do that, you shouldn't really be in mental
13 health to begin with.

14 So any clinical psychologist can
15 deal with those core issues and needs to know
16 how to do that work with families to figure out
17 what's going on in the background, and that's
18 the only requirement I recommend is somebody
19 who can do that and is willing to do that.

20 I've actually interviewed over the
21 phone a person who is sort of a transgender
22 oriented expert, and I had a wonderful
23 conversation with that particular psychologist,
24 who agreed with me totally that the issues need
25 to be delved into and that that was her

1 practice. So I felt very good about referring
2 patients to her specifically, because she was
3 going to -- at least she stated and I believed
4 that she was going to be dealing with the core
5 issues, or the foundation for all of these
6 issues.

7 Q. And you believe that people who
8 have a lot of trans experience as psychological
9 professionals and hold themselves out that way
10 don't deal with all of the other underlying
11 medical issues that you were highlighting?

12 MR. BLAKE: Objection. Misstates.
13 Go ahead.

14 THE WITNESS: Okay. What my
15 experience is in my testimony and listening to
16 and being questioned by and reading depositions
17 of individuals who have testified as experts,
18 the one particular individual who's the head of
19 the transgender clinic in Cincinnati, she
20 specifically said she had never had a patient
21 that came in that didn't go immediately to
22 social and medical transition, that 100 percent
23 of the patients who walk in the door are
24 transitioned.

25 I have had conversations with

1 parents and in some cases, cases where I've
2 done a medical statement of expert opinion,
3 where the family freely admits that no one
4 talked to them about any psychological issues.
5 My second most recent transgender patient, I
6 spoke to her psychological therapist about this
7 particular child.

8 A male who was a transfemale, and
9 this particular patient had not had any mental
10 health interventions until this psychologist
11 took up the case about a year ago, when the
12 child was having cutting behavior at school and
13 was referred by the school through their
14 psychological support services to a clinical
15 mental health professional. This child had
16 suffered inordinately from adverse events from
17 shortly after birth all the way up through the
18 present time and had never had an evaluation
19 but was recommended by the school that they
20 needed to consider transgender as the answer,
21 that they had some conversations with this
22 child.

23 And so the clinical psychologist
24 said suddenly, in February, that this child
25 decided that she was going to take on a male

1 name and a male persona at school. And she
2 said, so I went through, and since doing that
3 the child seems to be remarkably happy, has
4 stopped any self-harming behaviors.

5 And I said, okay, have you
6 interviewed the biological father? No. Have
7 you interviewed this person? No. I said,
8 well, I think it's probably important to delve
9 deeper into that.

10 So my experiences in dealing with
11 the cases where I've been asked to step in or
12 review that very often the initial evaluation
13 is not done. And as a matter of fact, this
14 document states that any such evaluation is
15 essentially harmful. This Dr. Rafferty said,
16 psychological evaluation is totally unnecessary
17 and does harm.

18 BY MS. INGELHART:

19 Q. Okay. I have a few questions.
20 We'll come back to that one. Okay. So in the
21 anecdote you just shared you said that the
22 child began -- sorry. The child that you just
23 referred to in that anecdote, what sex were
24 they assigned at birth?

25 A. Male.

1 Q. Okay.

2 A. No. Excuse me. Female. I'm
3 sorry. Female.

4 Q. Okay.

5 A. Assigned female, decided to take
6 on a male persona in February.

7 Q. Okay. And the medical
8 professional that you spoke with treating that
9 person, that child, said that since transition
10 they were remarkably happy?

11 A. Yes.

12 Q. Okay. Before you said that of the
13 15 patients that you deal with right now with
14 trans issues, each and every one came from a
15 dysfunctional family; is that correct.

16 A. They had significant family
17 dysfunction, yes.

18 Q. Okay. Could you give an example
19 of such family dysfunction?

20 A. Divorce.

21 Q. Okay.

22 A. Alcohol or drug abuse, mental
23 health issues of the parent, severe depression
24 or anxiety in the parent, death of a sibling,
25 death of a parent, frequent moves. Things that

1 are classified as adverse childhood events.

2 Q. Okay. Thank you. And who
3 classifies those as adverse childhood events?

4 A. It's a list. It's a published
5 list from -- I can't quote you the
6 organization, but there's a published list of
7 adverse childhood events, such as a
8 questionnaire that's proposed to be asked at
9 all general pediatric visits. It's a screen
10 for adverse childhood events.

11 Q. Okay.

12 A. There's a published screen.

13 Q. Yeah. So that list, that
14 screening is publicly used and accessed by most
15 pediatricians?

16 A. Yes.

17 Q. Okay.

18 A. It's available. It's not often
19 used.

20 Q. Oh, okay.

21 A. That's the problem. The
22 publications that say this should be part of a
23 pediatric well visit, they're trying to
24 advocate to get pediatricians to pay attention
25 to that.

1 Q. Okay. Why is it not often used?

2 A. Because pediatricians don't often
3 delve into behavioral health.

4 Q. Okay. Amongst the list of adverse
5 conditions or experiences, is being raised by
6 parents of the same sex among that list?

7 A. No.

8 Q. Okay. Okay. So I think we got
9 into this because we were talking about the
10 treatment of those 15 patients that you have
11 now. You do an intake, and you refer them to a
12 psychologist, because as you've stated you're
13 not an expert at who is a psychologist. From
14 that point, what's your relationship with those
15 witnesses?

16 A. As a place to come and sort of be,
17 if you will, a gate keeper to make sure that
18 the mental health issues are being dealt with.

19 Q. Okay. But you're not an mental
20 health expert, right?

21 A. No. But I'm in touch with
22 what's -- plus I provide education that is age
23 appropriate about what the risks and benefits
24 are of moving forward with affirmation,
25 medical, surgical or social.

1 Q. Okay.

2 A. And so I will present those to the
3 patient, because areas, a dream and a hope, and
4 then there is reality, and I want to make sure
5 that they have their dreams and hopes and all
6 the reality all in front of them at all times
7 in a level that they can understand.

8 So if I have a 10-year-old child,
9 I kind of go back through, and I interview. On
10 subsequent times I'll interview the parent, and
11 if I have only seen one parent, which is very
12 often the case, I will ask to visit with the
13 other parent if it's at all possible. The
14 biologic parent, the step parent, anybody
15 that's been in an authority role in this
16 child's interface. I want to have a chance to
17 interview those people. Siblings, if possible.
18 So that I can -- serve a broad spectrum of
19 what's going on in the relations of these kids.

20 Q. Okay.

21 A. So that happens spread over time,
22 because you can't get all that done. You can't
23 get everybody in the office at the same time.
24 Plus with younger children in particular, I
25 want to see what it is they remember that we

1 talked about at the prior visit, and really
2 commonly they don't remember or they state they
3 don't remember.

4 And so I want to make sure they
5 have an understanding. And I specifically ask,
6 you know, your sex is male or female. You're
7 at odds with that as believing who you are.
8 Are you aware that you can never become another
9 sex? And in the concrete thinking nine or
10 ten-year-old, they tend not to get that. They
11 don't understand that. In an older adolescent,
12 they can wrap their head around that as a
13 concept. So it's all based on age and mental
14 capacity and other things to see, what do you
15 understand? Because I don't want you to have a
16 sense that you were told something that is not
17 actually true. You need to be aware.

18 And for parents I provide them
19 with a list of references and say, this is
20 contrary to what you're telling me you've
21 understood, you've read and reviewed, from your
22 online searches. I'm going to give you actual
23 references that would show a different opinion.
24 Understand that the reason I'm giving them to
25 you is because it's in contrast to what you've

1 picked up in the way of information so far.
2 Among those, I try to choose references that
3 actually are balanced in terms of they have
4 looked at everything. They haven't just gone
5 to things that support an opinion and put those
6 in as references, but they have actually looked
7 at another side of the story, an affirmation
8 pathway. What are the things? And those are
9 brought up as references, and then they are
10 evaluated for their scientific validity, and
11 they're included in the treatise that I give
12 them.

13 So it's important I -- you know, I
14 said, you need to know everything. I don't
15 want you just to go down not knowing what's
16 really out there. And so that's an arduous
17 process, and it cannot be handled in just a
18 single visit. So the subsequent visits are all
19 about what do we know? What are you thinking?
20 What questions do you have for me?
21 Understanding that I will not be the one that's
22 going to provide hormone therapy.

23 Q. Got it. So your subsequent visits
24 are conversational check-ins?

25 A. Yes.

1 Q. Okay.

2 A. And if certain things are
3 happening and females who are menstruating and
4 if they are having issues with discomfort of
5 binding the breasts and things like that, I
6 talk to them about, you know, how to alleviate.
7 You know, if you're going to be wearing a
8 breast binder, please take it off if you can at
9 night. Wear it as little number of hours per
10 day as you can tolerate, because it basically
11 crushes the tissue, and it creates secondary
12 issues with shoulder musculature and posture
13 and things like that that sort of give them
14 some secondary problems. And so I try to point
15 out the things they could do to alleviate those
16 things that may be done at the present time.

17 Q. Okay. And that medical advice
18 that you're giving in those contacts for breast
19 binding, those aren't necessarily expertise
20 related to endocrinology; is that correct?

21 MR. BLAKE: Objection.

22 THE WITNESS: It's more general
23 pediatrics.

24 BY MS. INGELHART:

25 Q. The materials that you provide to

1 patients and family, what's in that treatise
2 specifically?

3 A. A balanced presentation.

4 Q. Okay. What is a balanced
5 presentation?

6 A. Means that I looked at the
7 opinions of both sides of an issue. It's like
8 how we do with clinical research. You know,
9 clinical research has to be balanced in order
10 to be ethical. It doesn't mean that you have
11 to have equal numbers of references. It
12 doesn't mean that you have to do -- if there is
13 something that's published that is opposite of
14 that, you need to make sure that the person
15 knows that you are aware of that and that it's
16 discussed. And if you're invalidating that,
17 the reason why that you would invalidate it.

18 Q. Okay.

19 A. So you haven't just quoted things
20 that you like. You've quoted things that you
21 find contrary.

22 Q. Okay. Okay. One more question,
23 and then we'll take a quick break.

24 A. Okay.

25 Q. So are you providing -- would you

1 characterize those ongoing check-ins as a type
2 of counseling?

3 A. In part, it's counseling.

4 Q. Okay. And you have these meetings
5 with patients as well as family members,
6 correct?

7 A. Yes.

8 Q. Okay. Do the family members and
9 the patients understand that you are not a
10 mental health professional?

11 A. They do.

12 MS. INGELHART: Okay. All right.
13 Let's take a quick bio break.

14 THE WITNESS: Okay.

15 (Thereupon, a break was taken.)

16 MS. INGELHART: Okay. Back on the
17 record.

18 BY MS. INGELHART:

19 Q. When we were discussing your
20 practice with the 14 or 15 children who
21 presented to you as gender dysphoric, you said
22 that, or something along the lines of, that
23 people know who you are, and therefore seek you
24 out. Is that kind of --

25 MR. BLAKE: Objection.

1 THE WITNESS: This is essentially
2 an opinion based on the fact that there's a
3 transgender clinic at Emory University. Three
4 years ago when they reviewed the number of
5 patients that were referred per year that were
6 active patients, not referred per year, they
7 had I think in the mid thirties. Two years
8 later they had increased AD patients that were
9 active patients in their clinic. They were
10 essentially the only advertised transgender
11 center in town that is academic based.

12 There is a treatment facility in
13 Decatur, Georgia called Queer Med, and I didn't
14 realize. I guess it's a franchised type of a
15 medical, because it exists in other cities I've
16 been told, and there is a family practice
17 doctor there who dispenses testosterone and
18 estrogen, does not use puberty blockers. He's
19 a family practice doctor. And the use of
20 puberty blockers is essentially restricted
21 because of insurance costs and whatnot to
22 pediatric endocrinologists and adult
23 oncologists, and so that person is unable to
24 write the prescription and have them be
25 accepted so doesn't do that.

1 So there are some, evidently, sort
2 of lesser, not academic affiliated places for
3 transgender patients to go in the Atlanta
4 metropolitan area. But the Emory Clinic has at
5 last full count 80 active patients in the year.
6 Well, I have 15 active patients over the past
7 three or four years. I am in a practice that
8 sees about 20 percent of the endocrine
9 population in the Atlanta metro area and the
10 Emory Children's Health Care Consortium sees
11 about 80 percent. I haven't really figured out
12 the proportionality of that, but I'm thinking
13 that if the majority of patients are going to
14 Emory, that they don't come to me for a
15 particular reason, and it's just sheerly a
16 guess.

17 BY MS. INGELHART:

18 Q. Okay. Do your patients or their
19 parents tell you why they choose to come to
20 you?

21 A. A couple of them have said, you
22 know, I know who you are. I've seen a video
23 presentation of one of your lectures, and I'm
24 here for that reason. I came for a second
25 opinion. One in particular.

1 Q. Okay.

2 A. That's sort of the one that sticks
3 in my mind.

4 Q. Okay. And so what are you
5 implying? They've seen your videos, and
6 therefore they come to you?

7 A. That I am all about psychologic
8 counseling and not about social, medical and
9 surgical affirmation.

10 Q. Okay. So is your goal to help
11 your patients align their gender with their
12 assigned sex through that counseling?

13 MR. BLAKE: Objection.

14 THE WITNESS: My goal is to make
15 sure they're mentally healthy and that that has
16 been addressed.

17 BY MS. INGELHART:

18 Q. Okay. Does being mentally healthy
19 relate to having a gender identity that aligns
20 with your birth assigned sex?

21 MR. BLAKE: Objection. Vague.
22 Relevance.

23 THE WITNESS: So I do not believe
24 that gender incongruence is an issue that is
25 separate from emotional trauma and emotional

1 malagendment (sic).

2 BY MS. INGELHART:

3 Q. Okay. But you know the parents of
4 these children, the guardians of these
5 children, some come to you because they are
6 aware of your medical opinions on trans issues,
7 correct?

8 MR. BLAKE: Objection.

9 THE WITNESS: Some of them.

10 BY MS. INGELHART:

11 Q. Okay. These 15 children are the
12 only ones you've ever treated with these
13 issues?

14 MR. BLAKE: Objection.

15 THE WITNESS: Yes. I'm familiar
16 with many more cases, because I've been
17 contacted by families who say, what resources
18 would you recommend for me in my community?

19 BY MS. INGELHART:

20 Q. I understand. Okay. So all 15
21 are currently active?

22 A. Yes.

23 Q. Okay. So none have left your
24 care?

25 A. Some have strayed away, and we've

1 had to recontact them. One in particular I
2 think we are attempting to kind of get back in
3 touch with, and I don't know whether or not
4 their purpose is they don't intend to come
5 back, but they're not very communicative. It's
6 been like nine months since I've seen that
7 patient.

8 Q. Okay. And what's your interest in
9 reaching back out to them to reconnect?

10 A. I care for them. I deeply care
11 for these kids.

12 Q. So do you believe or do you think
13 professionally that through psychotherapy you
14 can get a transgender patient to stop being
15 transgender?

16 MR. BLAKE: Objection.

17 THE WITNESS: I believe that the
18 desistance, so-call desistance rate, is
19 extremely high in both males and females, and
20 that if that is the case, then my job would be
21 to essentially minimize the kinds of medical
22 and psychological trauma that they're going to
23 have in their lifetime.

24 And so if we have emotional issues
25 that need healing, which I think is every

1 single case, and I can work them through and
2 they come out the other end without depression
3 and anxiety, that past the age of consent it's
4 their choice of what they're going to choose to
5 do. But as a child who cannot really consent
6 and whose brain is not capable, I believe, of
7 making those kinds of decisions,

8 I worry about them, you know,
9 falling into harm, and the harms are
10 unequivocally described in medical literature.
11 We are giving them a medical condition for the
12 rest of their life. They will need hormones
13 for the rest of their life. They will need
14 surgical manipulation and repair for the rest
15 of their life. They will not have biologic
16 function of the surgically altered body parts
17 for the rest of their life.

18 So there's just so much about
19 human physiology that's so complex. We have to
20 warn them about cancers, and we have to warn
21 them about stroke, and we have to warn them
22 about cardiovascular disease that they would
23 not have had if we hadn't have done these
24 things to them. And so to me that's a list of
25 horrific complications that far -- and of

1 course the big one is what if they're going to
2 kill themselves, because the suicide rate or
3 suicide attempt rate is so much higher.

4 And the answer to that is that the
5 data that is constantly referred to about the
6 41 percent of trans kids who are not allowed to
7 be socially affirmed will kill themselves -- or
8 attempt to kill themselves. Not a completed
9 suicide but an attempt at suicide. That is
10 actually from a study which didn't separate out
11 those which were counseled only and those that
12 actually had surgical interventions and medical
13 intervention. It was every one of the patients
14 in the group. The real article when you take
15 it apart is that it's a misrepresentation of
16 statistics to essentially push people -- and
17 this is stated over and over again. What would
18 you rather have, a dead child or a trans boy or
19 a trans girl? Okay?

20 And that's really not fair,
21 because the statistical evaluation doesn't show
22 that that's going to happen. The only
23 nonselective, nonbiased study about suicide
24 completion is the Dhejne study from Sweden.
25 Where every single patient, whether they wanted

1 to be included in the study or not, in the
2 country of Sweden everybody's medical records
3 are known.

4 So if they want to look at a
5 population study, they don't have to do a
6 survey and say, if you are trans or if you are
7 this or if you are that, are you interested in
8 being part of a study, please call this number.
9 We're interested in interviewing you and
10 hearing your opinions. This was completely
11 devoid of selection bias.

12 BY MS. INGELHART:

13 Q. Okay.

14 A. And a 20 fold increase in suicide
15 completion in those who were affirmed and
16 surgically treated. Now, they did not have in
17 their data those that were just medically and
18 not surgery confirmed. They also did not have
19 in their data a comparison of those who had
20 counseling only. Okay? They didn't.

21 Q. Okay. So --

22 A. That study is criticized as
23 flawed, because there was no control.

24 Q. Right. Right. Yes.

25 A. Okay?

1 Q. Okay.

2 A. So if that criticism is to be a
3 gold standard, okay, then all the studies that
4 are being done now moving forward prospectively
5 in the United States and around the world need
6 to have a control group.

7 Q. Right.

8 A. And none of them do, on purpose.
9 And the reason that they claim and they're
10 approved to do the clinical study in the NIH
11 study is, well, we're going to help cause them
12 to kill themselves otherwise. So we don't have
13 a control group. If we have a control group
14 who are just socially counseled and -- and --
15 so what's called watch and wait, the maddening
16 thing is that watch and wait is not a passive
17 non-intervention. It's an aggressive
18 intervention. Okay?

19 And conversion therapy, so-called,
20 or affirmation therapy, is actually converting.
21 An attempt to convert one sex to the other.
22 Which can't happen.

23 Q. Hold on real quick. So are you
24 saying that affirmation counseling is
25 conversion therapy?

1 A. Is an attempt to convert a male to
2 a female.

3 Q. Got it. So --

4 A. That's actually a conversion. To
5 me, that would be conversion.

6 Q. I just wanted to be clear on the
7 terms.

8 A. Affirmation is not really anything
9 other than trying to convert a male into a
10 female or vice versa. Okay? Conversion
11 therapy, as it's called, is actually going to
12 the psychological aspect of what's going on to
13 maintain, not convert. Not convert anything
14 but to maintain a congruence between the
15 concept of who the patient believes they are as
16 their gender, which is a psychologically based
17 thing -- it has no biologic basis whatsoever --
18 compared to biology and to get those aligned.
19 Because that happens as a result of
20 undercurrent psychological -- and then it self
21 propels. Okay?

22 Are these people traumatized
23 emotionally from society? Of course, they can
24 be. But in this particular paper it talks --
25 which is one of its fallacies -- it says that

1 all of the psychologic morbidity is essentially
2 caused by society. There is no internal basic
3 psychologic struggle as a basis for gender
4 incongruence, and that is patent nonsense.

5 Q. Can you explain what that patent
6 nonsense is?

7 A. Because we know that gender is a
8 psychologically based concept. It has no
9 biology. And that sex is biology. The
10 American Psychological Association, the APA,
11 DCM5, stated absolutely and utterly clearly
12 gender identity is a very fluid thing. People
13 go in and out of that, on and off, throughout
14 their lives. People don't go in and out of a
15 sex.

16 Q. Okay. So I think I saw that in
17 your report. The DSM-5 and the APA handbook
18 state what again? I'm sorry.

19 A. That there is no biologic basis
20 for gender, and the gender identity concept is
21 a fluid state.

22 Q. And you reviewed that recently?

23 A. Yes.

24 Q. Okay. Okay. So many questions.
25 The study -- I think you referred to the term

1 desist, correct?

2 A. Yes.

3 Q. Okay. And just for the record,
4 could you repeat what that definition is?

5 A. Okay. So desistance is the term
6 that has been applied to patients who had
7 gender identity disorder and who through
8 counseling came to align their gender identity
9 with their sex.

10 Q. Okay. And do you know what like
11 the study was that you were referring to for
12 that desistance rate?

13 A. There are several studies.
14 There's Kenneth Zucker's published studies of
15 all 560 of his patients, and then there is a
16 study from the Dutch protocol, Voorhees, I
17 believe is one of the authors of that that
18 looked at the desistance rate.

19 Q. Okay. And then the 19-fold
20 increase of completed suicides. What study is
21 that?

22 A. That's Dhejne.

23 Q. And that's spelled D --

24 A. -- j-e-i-n-e, I believe.

25 Q. Thank you. Okay. Okay.

1 A. It's often referred to as the
2 Swedish study.

3 Q. Yeah. I think I've heard that.
4 Okay. Great. We'll come back to that. Are
5 these materials a part of the education
6 materials that you provide to your patients and
7 their families?

8 A. Yes.

9 MS. INGELHART: Okay. We'd like
10 to request that. Do you want us to submit a
11 formal discovery request for that set of
12 documents, that treatise?

13 MR. BLAKE: You're requesting the
14 treatise?

15 MS. INGELHART: Yes. Correct.

16 MR. BLAKE: Okay. Noted.

17 MS. INGELHART: Would you like us
18 to --

19 MR. BLAKE: Is that something that
20 you can easily get?

21 THE WITNESS: Yes.

22 MR. BLAKE: Okay. Yeah, we should
23 be able to produce that.

24 MS. INGELHART: Okay. Cool.
25 Thanks.

1 THE WITNESS: Specifically, just
2 the Dhejne setting?

3 MS. INGELHART: No. The whole
4 treatise.

5 THE WITNESS: Okay. And then the
6 article, Mayer McHugh?

7 MS. INGELHART: Sure.

8 THE WITNESS: Okay.

9 MS. INGELHART: The ones that --
10 I'm not sure how you classify your treatise,
11 but the bundle of materials that you provide
12 that you said was balanced.

13 THE WITNESS: Sure.

14 BY MS. INGELHART:

15 Q. Okay. You referred your patients,
16 these 15 patients, out to outside mental health
17 professionals who provide the counseling. Are
18 they in the watch and wait program, the
19 counseling that you were talking about? Is
20 that the kind of treatment they're receiving?

21 A. No. It's just general mental
22 health care.

23 Q. Okay. But as it regards to
24 treating their gender dysphoria symptoms?

25 A. The symptoms of dysphoria are the

1 depression and the anxiety.

2 Q. Okay.

3 A. It's whether or not it's the
4 undercurrent or the reaction or a combination
5 of that, that's what's being addressed is
6 depression and anxiety.

7 Q. But would you consider that that
8 treatment plan is the watch and wait, as you
9 described it before?

10 A. Interestingly enough, it is what's
11 recommended by the endocrine society
12 guidelines, which says in-depth, comprehensive
13 evaluation of the patient and their family and
14 appropriate treatment.

15 Q. Okay.

16 A. So I'm following that part of the
17 endocrine society guidelines. And if I do, the
18 medical part never happens.

19 Q. Okay. And so if one of your 15
20 patients were to, prior to reaching age of
21 majority, have treatment with an outside mental
22 health professional and begin to present as the
23 gender that matches their sex assigned at
24 birth, would you see that as a case study that
25 you no longer need to keep active?

1 A. No.

2 LEFT: Objection.

3 THE WITNESS: No. I would keep
4 following the patient.

5 BY MS. INGELHART:

6 Q. Okay. Okay. So you wouldn't --

7 A. Perhaps less frequently, because I
8 would use the mental health provider as the
9 sort of, if you will, monitor of how things are
10 going.

11 Q. Okay. Okay. Oh, okay. You said
12 you read a lot of articles.

13 A. Yes.

14 Q. Like a ton. Can you recall
15 specifically a few that you've read recently?

16 A. The most recent one was an article
17 in a publication called Quilette,
18 Q-u-i-l-e-t-t-e, and it's a very beautifully
19 written treatise about sort of gender and
20 gender behaviors and the spectrum thereof.

21 Q. Okay.

22 A. And it's sort of enlightening.
23 It's sort of written from the mental health
24 perspective and not really from the standpoint
25 of endocrinology specifically.

1 I just read -- there are a number
2 of what I call throwaway publications, in that
3 they're not peer reviewed. They're just
4 invited people to come in and do opinions.
5 Endocrine News, Pediatric News, and those come
6 out sometimes twice a month or once a month.
7 Monthly, they'll have synopses of lectures that
8 are given, opinion pieces from people, and most
9 often those things are all completely and
10 utterly gender affirming.

11 Q. How do you subscribe to those?
12 How do you come up on those?

13 A. They're sent to you until you tell
14 them no. And even if you tell them no, they
15 still come.

16 Q. I get that. Thank you, Banana
17 Republic. Hey.

18 Who are the leader, in your
19 opinion, researchers in the area of gender
20 discordance?

21 A. Kenneth Zucker.

22 Q. Okay.

23 A. Paul McHugh.

24 Q. Can you spell McHugh for me,
25 please?

1 A. M-c, Capital H-u-g-h.

2 Q. Okay. Thank you.

3 A. David Pickup is a mental health
4 professional in Texas who writes extensively in
5 treats. Peter Lee, who is a pediatric
6 endocrinologist, emeritus retired faculty
7 member at Hershey. He does not write on the
8 subject, but he talks on the subject. It's
9 interesting, because academic figures tend not
10 to express anything contrary publicly.
11 Contrary to affirmation publicly.

12 Q. Okay. Can you explain what you
13 mean? I'm sorry. I think you're trying to
14 pull out something.

15 A. There is fear on the part of
16 academic pediatric endocrinologists to openly
17 state that affirmation is harmful.

18 Q. Okay. So did you mean that Lee
19 doesn't speak publicly, because he doesn't want
20 to share those affirmation type opinions
21 publicly?

22 A. Yes.

23 Q. Are Lee, Zucker, McHugh and Pickup
24 medical professionals who write or research or
25 print on affirmation type care?

1 A. Yes.

2 Q. Okay. As you would define
3 affirmation?

4 A. Yes.

5 Q. Okay. What's the best source for
6 learning the standards of care on professional
7 guidelines?

8 MR. BLAKE: Objection.

9 BY MS. INGELHART:

10 Q. In your opinion?

11 A. Well, standard of care and
12 guidelines are different.

13 Q. Okay.

14 A. So a standard of care from my
15 world view is something that is prepared
16 essentially to use as a legal document. I
17 mean, a statement -- you can be sued for
18 malpractice if you do something that is not a
19 standard of care, and there's an adverse
20 outcome.

21 Q. Okay.

22 A. A clinical guideline is just that.
23 It's a guideline. You know, these ideas that
24 we think generally are appropriate. We've got
25 literature that supports them or doesn't

1 support them, and we want you to know about
2 them. Because this is something that either is
3 confusing or perhaps controversial, and so we
4 want to be able to present what we think
5 experts in the field would recommend that you
6 do.

7 So the Endocrine Society does
8 clinical guidelines for a number of things.
9 Treatment of Cushing disease, for instance. If
10 it's a very complex thing, it's a very
11 difficult diagnosis to make, there's a lot of
12 murkiness in terms of the studies that you use
13 to come up with a conclusion to intervene and
14 treat, and because of that they developed
15 clinical guidelines. They just published the
16 clinical guidelines on congenital adrenal
17 hyperplasia. It can be and most often is a
18 mild form of a differential sexual -- disorder
19 of sex differentiation.

20 Treatment of Turner Syndrome.
21 These are things that are particularly in
22 pediatric endocrine purview.

23 Q. And so there's guidelines?

24 A. Right. They are guidelines. And
25 guidelines for treatment with adult males with

1 testosterone or post menopausal with hormonal
2 replacement therapy. So these are written not
3 as standards of care but to say, you know,
4 there are a lot of opinions on this. What
5 we've tried to do is to call the world's
6 literature and show you the scientific basis,
7 and the Endocrine Society guidelines are graded
8 on a scale of 1 to 4. 1 being no scientific
9 evidence whatsoever, and 4 being very strong
10 scientific evidence.

11 Q. Okay.

12 A. And so every one of their
13 recommendations has --

14 Q. I see.

15 A. Yeah. One or four checks or
16 circles filled in. And so that gives you, if
17 you're sort of a critical reviewer, an idea
18 about is this scientifically based or not.

19 Q. Okay.

20 A. And so interestingly the endocrine
21 society guidelines for transgender care, the
22 majority of them have either no or very little
23 published science to back them up.

24 Q. Okay.

25 A. And that's alarming, but, you

1 know, as a practitioner, if something comes out
2 as a clinical guideline and you are a busy
3 practitioner who doesn't often see these
4 things, and that's the case for most
5 endocrinologists up until now, is that
6 transgender patients were far and few between
7 and particularly in pediatrics. And so your
8 professional society comes out and publishes a
9 set of clinical guidelines, and you think,
10 okay, great, wow. You go to the summary. You
11 don't take the time necessarily to read through
12 it critically. Okay?

13 Q. Okay.

14 A. If you are part-time academician,
15 part-time clinical practitioner, you read
16 everything in absolute and utter detail. Okay?
17 And academic programs and their journal clubs
18 will very specifically take an article like
19 this, and they will literally take it totally
20 apart. They'll go to every reference. They'll
21 go back through. They'll go out and research
22 things that, this paragraph says here, guess
23 what I found. You know, a study in the journal
24 of whatever or whatever that's completely
25 against this. Okay?

1 Q. Okay.

2 A. So that's not done by
3 endocrinologists in general or by pediatric
4 endocrinologists in general. And in clinical
5 practice, you know, I see patients four days a
6 week and admin stuff sprinkled in. Four full
7 days, if you count all the hours up, and, you
8 know, I haven't got time to do that unless I
9 make an effort.

10 Q. Right.

11 A. So I tend to just pay a lot more
12 attention to the transgender stuff, because it
13 becomes for me a necessity that somebody's got
14 to do the job.

15 Q. Okay.

16 A. And I'm willing to take the time
17 to do that as best I can. The person that
18 critiqued this article actually went through
19 from stem to stern and point by point by point.
20 Something I would love to have the time to do
21 but didn't, and it was sort of done for me by
22 somebody who was clearly -- he actually is a
23 very LGB activist psychologist.

24 Q. LGB?

25 A. LGB. Yeah. And he said, whoa,

1 whoa, whoa, whoa. You know. Let's look at
2 this in-depth, because this is a
3 misrepresentation of facts.

4 Q. And the doctor who did that kind
5 of annotation and the new article, did you say
6 that was Dr. Cox?

7 A. Cox. C-o-x. And I can actually
8 get a copy of that to you.

9 Q. That would be great.

10 A. I don't have it on my memory. If
11 you'll remind me to provide that.

12 Q. Thank you. We would appreciate
13 that. Okay. And -- oh, shoot. I lost my
14 train of thought. Oh, okay. So guidelines are
15 found in documents like what we're looking at.
16 They are often, I don't want to say always,
17 often created by professional associations in
18 that specific field, but they're not the same
19 -- they're not using the same weight in like a
20 legal malpractice proceeding? They're just
21 guidelines?

22 A. That's correct.

23 Q. Where are standards of care found,
24 or how is that established?

25 A. If somebody wants to establish a

1 set of things that this is what should be done
2 and this is what's right and this is what's
3 wrong, and they just create those, and they
4 publish them.

5 Q. Who does that?

6 A. WPATH did that in this case. I
7 don't know other standards of care,
8 specifically, but I'm sure they do exist,
9 because I have been asked in medical testimony
10 and depositions and stuff, are you aware of
11 standards of care versus clinical guidelines.
12 So I got most of my information about the
13 difference of those from attorneys in sort of
14 malpractice cases, particularly.

15 Q. Okay. Okay. So what's the best
16 source for learning standards of care?

17 MR. BLAKE: Objection.

18 BY MS. INGELHART:

19 Q. What do you use to learn or to
20 access standards of care?

21 A. I don't often access standards of
22 care.

23 Q. Okay.

24 A. I look for clinical guidelines for
25 support.

1 Q. All right. Were you on faculty
2 between -- anywhere between 1978 and 1980?

3 A. Yes.

4 Q. Where were you?

5 A. 1978 to -- excuse me. From 1976
6 to '78, I was at LSU School of Medicine. I was
7 a fellow until -- 1980 to 1986 I was on
8 clinical faculty at UC San Diego Medical
9 School. From 1986 to 1991 I was clinical
10 faculty at University of California San
11 Francisco School of Medicine.

12 Q. Okay.

13 A. And from that to Emory and
14 Morehouse.

15 Q. And when did you leave the UC
16 system?

17 A. I was transferred when I completed
18 my Navy career and moved to Atlanta.

19 Q. Did the Navy transfer you to
20 Atlanta?

21 A. No. I finished my career, and
22 that was my final move after I -- they say,
23 goodbye, thanks, and move you to wherever
24 you're going to go.

25 Q. Oh, they moved --

1 A. They move you, yeah.

2 Q. So you choose where you want to
3 go, and the government --

4 A. Yeah. Yeah.

5 Q. -- as a nice gift says, we'll pay
6 for that --

7 A. Right.

8 Q. -- expensive across country?

9 A. Right.

10 Q. Got it. Why did you choose
11 Atlanta?

12 A. One of the job opportunities that
13 was available was in Southern Suburbs of
14 Atlanta, in Fayette County, Georgia.

15 Q. One of the pediatricians in the
16 multi-specialty group was a resident that I had
17 trained with many, many years before. He had
18 left the Navy after a very short period of
19 time, and he was done with his obligated
20 service and moved back to Georgia and then was
21 recruited from his home in Macon to come up to
22 Fayette County, Georgia to practice. And they
23 were looking for a pediatrician, and he knew me
24 and he said, would you come look?

25 And I said, Georgia? I don't know

1 anything about Georgia. We had no roots there,
2 no family, no experience whatsoever. And
3 landed there and put our feet in red clay and
4 probably will never leave.

5 Q. It's a great state.

6 A. Yeah.

7 Q. Well, thank you. You've never
8 worked as a mental health professional, right?

9 MR. BLAKE: Objection.

10 THE WITNESS: Not as a certified
11 mental health professional, no.

12 BY MS. INGELHART:

13 Q. You never worked as a
14 psychologist, correct?

15 A. No.

16 Q. Or as a psychiatrist?

17 A. No.

18 Q. You've never worked as a
19 geneticist either, correct?

20 A. No.

21 Q. What's the age range of your
22 patients?

23 A. Birth to completion of first
24 undergraduate degree in college. So it's 22,
25 23. I have very few patients who are in their

1 late 20s who are neurologically compromised,
2 and they're essentially children for all
3 intents and purposes, an adult. Endocrine
4 folks don't like to take care of them. So
5 we're their home.

6 Q. Are those patients often patients
7 you've treated over the course of their life?

8 A. Yes. I don't often accept
9 patients past 18, who have not been with me
10 before.

11 Q. Okay. Have you treated children
12 with intersex conditions?

13 A. Yes.

14 Q. Do you currently treat children
15 with intersex conditions?

16 A. Yes.

17 Q. How many do you currently treat?

18 A. I think the number of active
19 patients I have now, perhaps 20 kids who have
20 adrenal hyperplasia, which is a very, very mild
21 form.

22 Q. Okay.

23 A. I have I think four patients with
24 complete androgen insensitivity.

25 Q. Okay.

1 A. I have one patient who is referred
2 to as an XX male. That's sort of a catch
3 basket. No one understands specifically what
4 happened, but his karyotype is XX, and he had
5 all male genitalia, produced testosterone.
6 It's just one of those very rare -- super rare
7 ones.

8 I have, gosh, two or three dozen
9 Klinefelter's kids, but I don't consider them
10 DSDs at all. That's an inappropriate use of
11 the term.

12 Q. Why is that?

13 A. Because it's not a sexual
14 differentiation issue. They have an extra X
15 chromosome, but the only effect is it causes
16 infertility to them. They have no anatomic
17 female organs anywhere, and there's no
18 ambiguity of genitalia whatsoever. They just
19 have dysfunctional testes.

20 Q. Okay. So it affects their
21 reproduction. What about the XX male? It
22 sounds like they don't have --

23 A. This particular one -- I've never
24 had anybody tell me they've ever treated one
25 before. It was so rare that essentially it's

1 not even in endocrine textbooks really. It's
2 in genetics literature. This is a boy who's
3 autistic, who has male genitalia, and when they
4 did the -- I can't remember specifically. Oh,
5 Mom had an -- she was older. So they did in
6 the pregnancy, sort of when you have a boy or
7 girl or any Down syndrome or whatever, so she
8 had an amniocentesis which said XX. So they
9 were all prepared for a girl. This was
10 pre-ultrasound. They weren't doing ultrasounds
11 routinely on every pregnancy that looked at
12 genitalia back then. Ultrasound technology was
13 relatively crude, and they weren't thinking
14 they needed to do that.

15 And so out comes a baby boy, and
16 they said, no, no, no, no. What's wrong with
17 this? Testicles descended. No ambiguity of
18 genitalia whatsoever. So they repeated the
19 chromosome analysis in the baby and came up
20 with XX. A hundred percent XX. So that
21 startled everybody, and that got me to go
22 searching, and I found the entity of XX male,
23 and that's what this child had.

24 Q. Okay. And that male has endocrine
25 medical needs?

1 A. No. Actually, did not. There was
2 a point in time where the testes sort of became
3 retractile and very difficult to find, but they
4 were there at birth. I had documented they
5 were there at birth, and then I kept following
6 him just out of curiosity. I mean I'm not
7 going to need to do any medical treatment, but
8 this is an educational experience for me. And
9 because of his autism and the fact that I was
10 also a general pediatrician in practice at that
11 time, I became that child's general
12 pediatrician and followed him along for routine
13 medical care.

14 And then when I left my pediatric
15 practice behind in 2003 and did full-time
16 endocrine, the mom just came over to me and
17 said, can I continue to come to you even though
18 there's no really endocrine issues at all?

19 I made sure that he went through
20 puberty appropriately, which he did.
21 Everything was smooth. Hormone levels were
22 fine. There was no evidence of any gonadal
23 damage, and the autism was the key. The key
24 problem for him.

25 Q. Okay. Have you done any

1 scientific research related to the gender
2 dysphoria?

3 A. I have not.

4 Q. Related generally to transgender
5 people?

6 A. No.

7 Q. Anything related to any gender
8 issues in scientific research?

9 A. No.

10 Q. Okay. Have you published any
11 books or articles addressing gender dysphoria?

12 A. I have.

13 Q. What are those?

14 A. Most recently is actually an
15 article that will come out in October in Issues
16 in Law and Medicine, and it's a sort of
17 comparison of counseling treatment, so-called
18 watch and wait, versus affirmation, and the
19 pathways for each and the known outcomes for
20 each that are in published literature.

21 Q. And just to be clear for the
22 record, watch and wait versus affirmation,
23 affirmation in this context means gender
24 affirming affirmation?

25 A. That's correct.

1 Q. Thank you. Okay. How does one
2 get an article published in Issues in the Law?

3 MR. BLAKE: Objection.

4 BY MS. INGELHART:

5 Q. Oh. And Medicine. I'm sorry.

6 A. You're either invited to send it
7 in for peer review, or you can volunteer and
8 send it in for review. Either way.

9 Q. So it's a peer review journal?

10 A. It's a peer review journal.

11 Q. Got it.

12 A. I'm sorry.

13 Q. I should have asked that more
14 artfully. Okay. Issues in Law and Medicine.
15 Will your article have both issues of law and
16 medicine discussed within it?

17 A. No.

18 Q. Will your articles just have
19 issues of medicine discussed with that?

20 A. Yes.

21 Q. Okay. So then will your peer
22 reviewers also only be medical professionals?

23 A. I think there are bioethic people
24 as well. So it crosses over a bit into law.

25 Q. Oh, okay. Bioethics and an area

1 of law.

2 A. Yeah.

3 Q. Okay. I understand. So that's
4 the most recent one, and have you published
5 other articles or books -- or articles, I
6 guess?

7 A. Let me think. I mean we did the
8 letter to the editor of Journal of Clinical
9 Endocrinology Metabolism, which was published
10 in March of 2019.

11 Q. Okay.

12 A. And that was essentially a
13 critique of the 2017 guidelines.

14 Q. And that was not a peer reviewed
15 article. It was a letter to the editor?

16 A. It was a letter to the editor,
17 yeah. It's very difficult to get anything
18 published.

19 Q. Agreed. Okay. You belong to
20 professional associations, correct?

21 A. Yes.

22 Q. Could you list that? Do you know
23 them off the top of your head?

24 A. The endocrine Society, which it
25 requires training in the field of

1 endocrinology.

2 Q. Okay.

3 A. I don't think board certification
4 is required. I belong to the Georgia Chapter
5 of the American Academy of Pediatrics, but I
6 left the membership with the National American
7 Academy of Pediatrics five years ago.

8 Q. And why did you leave?

9 A. I just got tired of nonsense.

10 Q. Okay. What nonsense?

11 A. Policy statements like this one
12 that are based on profound lack of valid
13 science. Essentially, it became a social
14 political organization and not a medical
15 professional organization in my personal
16 opinion. The Georgia Chapter maintains a
17 strong interest in legislative efforts in the
18 State of Georgia for the benefit and welfare of
19 children, which is most often devoid of social
20 activism. If it's activism, it's activism in
21 general for the proven benefit of children.
22 Its concept is if it's good for children, then
23 Georgia Chapter generally will be supportive.
24 It's not completely, but it's way more than the
25 national organization, its parent organization.

1 I belong to the American Diabetes
2 Association, which is just dues paying. You
3 are a professional member or a nonprofessional
4 member.

5 I belong to the Pediatric
6 Endocrine Society, which is a national
7 organization. And I honestly don't know
8 whether a degree is required, but the
9 membership categories are if you're a
10 practicing and board certified endocrinologist,
11 you're sort of listed one way. If you're an
12 affiliate, you're listed. Or if you're from a
13 foreign country, you can be an affiliate.

14 Q. Okay.

15 A. I am a member of the American
16 College of Pediatricians. Which is a
17 professional organization established in 2002,
18 I believe.

19 Q. Okay.

20 A. And it's an organization that
21 specifically looked at the American Academy of
22 Pediatrics as an organization politically
23 bound, and they wanted politics to be separate
24 from that, and so that they said, if we can't
25 make decisions that are based on valid science,

1 that the goal is specifically what is
2 scientifically proven to be a clear benefit to
3 children and recommended those policies. And
4 so we have some things in common with the
5 American Academy of Pediatrics on a number of
6 things.

7 We're a little easier to get up
8 and run and make a statement about particular
9 things, because our size is significantly
10 smaller, and we can access our membership
11 fairly quickly and get a read from the
12 membership and executive board and board
13 members to say, is this a concern that we
14 should address or not? The American Academy of
15 Pediatrics says 67,000 members. It's a
16 gigantic organization centered near Chicago.
17 It used to be a group that would listen to the
18 constituency, bring in input and sort of digest
19 it. But over the past 30 years it's moved
20 completely away from that and is essentially
21 run by an executive committee of 12 members and
22 a, if you will, sort of a cadre of long-term
23 career people that are the bureaucrats within
24 the organization, who essentially run the
25 organization.

1 And I maintained my membership in
2 that organization as long as I could. I was on
3 their committee looking at guidelines and
4 appropriate things for peer reviewed education
5 opportunities and growth pubertal development.
6 That was sort of easy to do, because there
7 really wasn't any controversy. There were
8 things that were beginning to creep in that
9 were inaccurate that I was able and I felt my
10 input was listened to and other people had
11 their opinion, and their educational material
12 then was guided back to a more essential and
13 scientifically based educational treatise.

14 On the case of obesity they went
15 off the deep end, and it's very difficult for
16 me to read what they recommend and what they
17 say, because it turns out it doesn't work. And
18 that's my own personal opinion. I have an
19 enormous amount of clinical experience with
20 obese children, approaching it in a vastly
21 different way and coming out with a remarkably
22 successful treatment option that works.
23 Whereas, what they're recommending is just the
24 same thing it has been forever, and it's not
25 successful. Ten percent success rate over

1 obesity. I have about a 75 percent success
2 rate.

3 And I gave input to that
4 committee, and it was as if I weren't even in
5 the room or on the telephone call. And I
6 decided, you know, I just -- I'm spinning my
7 wheels, and I'm not getting anywhere. It's
8 just yet another reason why I really don't want
9 to spend my time and effort at the American
10 Academy of Pediatrics. So I left that
11 organization finally.

12 Q. Why didn't they listen to your
13 opinions about the obesity?

14 A. Because I'm a private practitioner
15 that doesn't do clinical research.

16 Q. Okay.

17 A. The American Academy of Pediatrics
18 began as an organization not of academicians
19 but of practicing physicians.

20 Q. Okay.

21 A. And actually the academic
22 pediatric community, their professional
23 organizations were the American Pediatric
24 Association and the Society for Pediatric
25 Research. Very small cadre of academic

1 pediatricians who -- and I happen to be a
2 member of the regional meetings for the Society
3 for Pediatric Research and got to know a lot
4 about how those organizations work and what
5 their interests were, and it was a very snobby
6 academic environment that looked down on the
7 American Academy of Pediatrics as general
8 practitioners who were just local yocals. I
9 mean, honestly, what were used to be referred
10 to as LMDs. Okay? Local medical doctors.

11 Q. Oh.

12 A. People who were not in touch with
13 academia.

14 Q. Okay.

15 A. Okay. The AAP as an organization
16 had tons of members, because it provided an
17 opportunity for CME. Gave conferences dozens
18 of times a year regionally, nationally, twice a
19 year, worked hand-in-hand with the governing
20 boards of the certification societies and
21 whatnot, and the academic pediatricians saw
22 that as a need. They needed to be involved in
23 that and stop looking down at them. So they
24 basically came in and essentially took over the
25 organization.

1 And it does not represent
2 pediatricians. It represents academic
3 interests and social theory and politics. And
4 it's just like -- politics exist. They're
5 going to. But when you start making policy
6 statements like this and others that are an
7 embarrassment in terms of lack of scientific
8 validity, and they are not the opinion of the
9 membership. They are the opinion of a
10 committee. Okay? This paper does not
11 represent the opinion of pediatricians at all.

12 Q. How do you know that?

13 A. Because I've talked to
14 pediatricians. All my referring pediatricians
15 that know me. They were not asked. This was
16 not put out for a review and your opinion. The
17 American College, however, sends absolutely
18 every policy statement out to the full
19 membership and will not publish anything as a
20 policy statement unless it has approval of 75
21 percent of membership.

22 Q. How big is the membership of the
23 college?

24 A. It exceeds 500.

25 Q. And how big is the membership of

1 the AAP?

2 A. 67,000.

3 Q. Okay. So you mentioned opinions,
4 politics, et cetera, at the AAP that you
5 disagreed with. You also said there was
6 conflict with your professional opinions about
7 trans issues and OBC. Were there any other
8 areas of medicine?

9 A. Attention deficit disorder,
10 learning disabilities, in terms of the
11 evaluation, and that really kind of jelled in
12 with attention deficit disorder as an entity.
13 It's another entity for which there is no
14 diagnostic test. Okay? It's treated. The
15 pharmacology industry has answers to
16 everything, and as a general pediatrician who
17 perks it from a different world view and was
18 much more successful in handling things and
19 actually getting to the root of the problems, I
20 had total disagreement with the guidelines and
21 representation there.

22 There were some developmental
23 pediatrician -- developmental pediatrics
24 became, aside from neurology, a subspecialty
25 that was full of really strange people who were

1 not dealing with science at all and who were
2 invited to speak and again were an
3 embarrassment because of their clearly sort of
4 anecdotal approach to everything.

5 Q. Were they doctors?

6 A. Yeah.

7 Q. Oh, okay.

8 A. They were pediatricians, actually.

9 Q. Okay.

10 A. So medicine is full of things like
11 that. Again, when there are battles to choose
12 that you think you can possibly make a
13 difference with and the scope of trying to
14 approach ASMA management, from my standpoint, I
15 was a tiny, tiny, tiny, tiny drop in an ocean,
16 and I knew that I wasn't going to get anywhere
17 trying to fight that battle.

18 I just took care of my patients,
19 and I did well. I did much better by then,
20 because of my methods of treatment. Then those
21 that were recommended by the AAP and
22 guidelines, and so, you know, it's a situation
23 where always the focus is exactly what is best
24 for the children, what works, what creates the
25 least harm and what shows ongoing constant

1 compassion for the patient and why they came to
2 see you.

3 Q. Okay. Thank you. So I understand
4 your relationship with the American Academy of
5 Pediatrics and the Georgia Chapter. Are you a
6 leader or an officer in the Pediatric Endocrine
7 Society?

8 A. No, I'm not.

9 Q. Okay. How many members are in
10 that group? Do you know?

11 A. I don't know. I would guess about
12 a thousand.

13 Q. Okay. Do you know whether the
14 Pediatric Endocrine Society has a policy
15 statement on the treatment of trans or --

16 A. They do. They do.

17 Q. Okay. Are you familiar with that?

18 A. I am.

19 (Thereupon, Plaintiffs' Exhibit 2,
20 Statement on gender-affirmative approach to
21 care from the pediatric endocrine society
22 special interest group on transgender health,
23 was marked for identification purposes.)

24 BY MS. INGELHART:

25 Q. Okay. Plaintiffs' Exhibit 2. So

1 do you recognize this document?

2 A. I do.

3 Q. And what is it?

4 A. It's a statement on
5 gender-affirmative approach to care from the
6 pediatric endocrine society special interest
7 group on transgender health.

8 Q. Okay. Could we turn to what is
9 the second page, but it's called Page 476 here?

10 A. Yes.

11 Q. And look in the section on the
12 right-hand column called mental health care of
13 transgender youth. Do you disagree with this
14 first paragraph statement here, there are no
15 data to support the use of reparative or
16 conversion therapy with the intention of
17 changing one's gender identity or sexual
18 orientation? Furthermore, the American
19 Psychological Association, the American
20 Psychiatric Association and the American
21 Academy of Pediatrics, reject this form of
22 therapy and support a more trans-affirmative
23 model of care?

24 A. I'm totally in opposition to that
25 statement.

1 Q. Okay. And why is that?

2 A. Because it has no scientific
3 validity.

4 Q. Okay. So you --

5 A. You know, the term -- and this is
6 a common thing -- reparative or conversion
7 therapy refers to essentially talk therapy.
8 You know, there is no standard of care that has
9 been practiced that anyone is aware of or can
10 prove has ever actually happened, and there
11 are cases brought against them, litigation
12 against an individual, for electric shock and
13 rape and all the things that are constantly
14 brought up as what conversion therapy is or
15 aversive therapy. Ice baths and things like
16 that. Rubber band shocks and things like that.
17 That's not a standard of care, but it's always
18 referred to.

19 So if they're talking about those
20 things, yes, but those are not ever recommended
21 by anybody who is a reputable practitioner in
22 mental health, who's trained, who has any
23 certification. Are they done? I have no idea,
24 but there are no case reports of them actually
25 having been done.

1 There are anecdotal reports of
2 this was done to me. It's kind of like the
3 movie Monty Python and the Holy Grail. How do
4 you know she's a witch? Well, she turned me
5 into a newt. Are you familiar with that
6 particular scene?

7 Q. No. I don't think I understand
8 that message.

9 A. And of course the man is not a
10 newt, and the people around him look at him and
11 say, what? And he says, oh, but I got better.

12 Q. Okay.

13 A. So that is the validity. An
14 anecdotal report without any scientific or
15 documented actual happening. Just a statement
16 by somebody. Okay?

17 Q. Okay.

18 A. So that to me immediately negates
19 the entire thing, because we're not talking
20 about conversion at all. We're not talking
21 about reparative, unless you're trying to
22 repair mental health issues and repair
23 depression, anxiety, and in that case that is a
24 repair, if you will. But that is meant as a
25 pejorative term as harm. Okay?

1 And so by stating that, I know
2 already the entire bias. I happen to know Dr.
3 Rosenthal personally. I've known him since he
4 was in his fellowship training.

5 Q. Okay.

6 A. He is very agenda driven, and he's
7 never left academia. He's only been where he
8 trained. He's at UC San Francisco where he was
9 a fellow, and he's never departed from there.
10 I often, knowing him as I do and having been
11 familiar with that training program that he
12 came from, his mentors in that training program
13 are all deceased at this point in time, but
14 they were notorious for ripping to shreds, even
15 ripping each other to shreds, over the lack of
16 scientific validity of things. And if I have
17 an opportunity, without being -- not affronting
18 him in any way, I would like to say, Stephen,
19 none of this would hold up with your faculty
20 members. They would have torn this to shreds,
21 because it's not based on science, and you know
22 it, and I know it. Okay?

23 Q. Okay. So have you reviewed this
24 entire document?

25 A. I have. I have. I can't quote

1 chapter and verse, but when it came out I read
2 it. I actually read the proposed version and
3 sent in a critique of it. It was invited,
4 interestingly, by Stephen Rosenthal to
5 specifically write critiques. He specifically
6 said after -- and this is how I know my letter
7 to the Endocrine Society and my critique of
8 their guidelines, because he was on that
9 committee as well -- the things that I
10 critiqued about the Endocrine Society
11 guidelines he specifically in the invite to
12 critique these guidelines said, above all,
13 don't bring up this, this and this. Which
14 were the things that I brought up and others
15 had brought up. So he was aware of the things
16 that they didn't want, and they didn't include
17 anything here in these guidelines, didn't
18 change anything.

19 Q. What were those things?

20 A. Just the lack of scientific
21 validity and the issues of harm done by what's
22 called talk therapy and avoidance. You know,
23 statements like the undercurrent emotional
24 issues don't exist. They're only reactive.
25 And it says it right in here.

1 Q. Okay. So is talk therapy
2 conversion therapy? I'm confused.

3 A. Talk therapy is called conversion
4 therapy, yeah. Talk therapy is essentially
5 conversion therapy. That's what they're
6 referring to.

7 Q. And talk therapy is not the type
8 of therapy you get when you watch and wait?

9 A. No.

10 Q. Okay. Okay. Okay. So you're
11 just saying that they're using terms that you
12 think represent something else here?

13 A. Yes.

14 Q. Okay.

15 A. And the next paragraph, although
16 rates of depression are two to three times
17 higher in transgender youth versus non, it's
18 basically in response to societal rejection.
19 Okay? Totally unvalidated.

20 Q. What's unvalidated? I'm sorry.

21 A. That their suicide and depression
22 and anxiety is related to societal rejection
23 entirely.

24 Q. So it's been unvalidated in
25 scientific data that societal pressures lead to

1 those mental health issues?

2 A. They are not the -- these kids
3 have these issues beforehand. It's been
4 conservatively stated that 70 percent of
5 transgender kids have undercurrent emotional
6 issues. In my clinical experience, it's a
7 hundred percent. So it depends on what you
8 term psychological morbidity coming in.

9 But this paper says, essentially,
10 that all of that is entirely societal, and that
11 worrying about trying to do talk therapy to go
12 look at what's really in the basement and the
13 cobwebs is inappropriate and unnecessary. And
14 that's what this statement said, as well. So
15 it basically takes talk therapy and evaluation,
16 in-depth psychological evaluation and says
17 don't do it.

18 Q. I see. Oh, shoot. If it comes to
19 me, I'll ask it later.

20 A. Okay.

21 Q. Okay. So looking to the key
22 points section here on the same Page 2, at the
23 top, do you disagree with this first bullet
24 point that sex chromosomes and/or genitalia do
25 not determine one's gender identity?

1 A. I would agree with that, yes.

2 Q. So sex chromosomes and genitalia
3 do not determine one's gender identity?

4 A. They're not a definitive
5 determination of gender identity, because
6 gender identity is a fluid concept of a
7 psychological basis.

8 Q. Okay.

9 A. So they are essentially many times
10 related, but they don't determine one's gender
11 identity entirely. Because gender identity
12 disorder or gender dysphoria is caused by the
13 fact that there is a discordance between those
14 two.

15 Q. Oh, that was my question. So if
16 it's in your opinion that trans youths who
17 experience these mental health issues that are
18 concurrent with gender dysphoria and/or a
19 symptom in the criteria of gender dysphoria
20 aren't due to societal...

21 A. Rejection?

22 Q. Yes. Societal factors,
23 environmental factors, from whence do you
24 believe those mental health issues come from?

25 MR. BLAKE: Objection. Vague.

1 Misstates.

2 Go ahead.

3 THE WITNESS: From adverse
4 childhood events.

5 BY MS. INGELHART:

6 Q. Okay. Okay. Is it possible that
7 adverse childhood events could be related to
8 somebody's gender non-congruity?

9 MR. BLAKE: Objection.
10 Hypothetical. Vague.

11 Go ahead.

12 THE WITNESS: Down the pike later,
13 as the patient is rejected by family members or
14 peers, it could cause some secondary rejection
15 issues.

16 BY MS. INGELHART:

17 Q. Okay. Okay. So do you believe
18 that talk therapy is the appropriate course of
19 treatment to get someone's gender identity to
20 realign with their birth assigned sex?

21 MR. BLAKE: Objection.

22 THE WITNESS: It is the most
23 effective, proven most effective means to
24 relieve gender dysphoria.

25 BY MS. INGELHART:

1 Q. Okay. We can set this aside for
2 now. We might come back to it. I apologize.
3 Can we take another break? Is that okay?

4 THE COURT REPORTER: Sure.

5 (Thereupon, a break was taken.)

6 BY MS. INGELHART:

7 Q. Okay. I think we left off talking
8 about the Pediatric Endocrine Society; is that
9 right?

10 A. Right.

11 Q. Okay. And we were looking at that
12 document. Actually, do you want to refer back
13 to it real quick?

14 Here. There's where I put mine.
15 Thank you.

16 Okay. I just wanted to quickly
17 look to the bottom of Page 476 here, where it
18 talks about desistance, I think. So the author
19 notes it's important to note that not all young
20 gender-nonconforming children will persist as
21 such into adolescence, and that there might be
22 different paths of gender development and
23 degrees of complexity. This has raised the
24 concern about supporting an early social
25 transition in young children who may not

1 persist into adolescence. However, previous
2 studies may have underestimated or
3 misunderstood the likelihood of the long-term
4 persistence.

5 And then it highlights, I think, a
6 couple key issues that could explain, though
7 the author does not assert that they do, in the
8 left column. A key issue is that criteria for
9 gender identity disorder from early versions of
10 the DSM on which the studies were based
11 included diagnosis on the basis of gender
12 atypical expression alone, which may or may not
13 be independent of gender identity. Some have
14 suggested that the proportion of persisters
15 would likely be higher by applying current
16 gender dysphoria criteria and, for example,
17 including individuals who continue to express a
18 desire to be of the opposite sex or to believe
19 that they were the opposite sex, regardless of
20 gender-stereotypical behaviors per se.

21 I know that's a little wordy. We
22 did talk about earlier that Dr. Zucker's study
23 was based on the gender identity disorder
24 criteria, right?

25 A. The two were of the same actually,

1 So the name changed only because the -- and
2 this is from Dr. Zucker's own personal
3 statements and the people who understood the
4 process. The APA committee wanted to
5 completely remove gender identity as any kind
6 of pathology or any kind of morbidity
7 whatsoever. They wanted it stricken. And so
8 Dr. Zucker was profoundly against that. He
9 sort of held out and said, if you do that, then
10 all the patients that I've treated will have no
11 ability to have their care covered by
12 third-party payers.

13 So I am willing to compromise and
14 call this a gender dysphoria, because that --
15 if it's a category you're willing to agree
16 exists, is a level that will allow then to have
17 a code, a DSM code, that we can put on and
18 match in payments for services. DSM is all
19 about mental health being quantified and
20 interventions being quantified. And without
21 that you can't say, I had an hour session with
22 a cranky, angry teenager. Well, what's that
23 diagnosis? Cranky? No, that's not a
24 diagnosis. Oh, but oppositional defiant
25 disorder is a diagnosis. So we're going to put

1 a name to it. We have to give it some sort of
2 entity that we all are going to agree exists,
3 so that there's coverage for your service.

4 So gender dysphoria in his mind
5 encompassed everybody who had gender
6 incongruence at all.

7 Q. Right.

8 A. Okay. Anybody. And so he took
9 all those patients, and that's what he took.
10 His was actually a very concrete definable
11 entity. And so he's been criticized that, oh,
12 well back then, the desisters really were not
13 gender dysphoric. Therefore, you were over --
14 you know. You know. And the answer is that's
15 patent B.S. It really is. You're just
16 basically saying anything that was old and
17 previously published that we don't agree with
18 is counter to promoting affirmation only.

19 And Zucker did not do that.
20 Zucker was all about talk therapy, all about
21 discovery, all about mental health issues as a
22 basis. And here he was the world's leader in
23 literature, and the WPATH bibliography at the
24 time when he was running his clinic initially
25 quoted that he was a WPATH member. He was on

1 their board. I don't know that he ever assumed
2 the office of presidency of that organization,
3 but clearly a strong advocate for people who
4 were transgender. And subsequently the
5 biography eliminated most of his references.

6 Here he was the person who was
7 responsible for getting care for these kids and
8 really working with them, and he was soundly
9 rejected, and his clinic was shuttered by
10 activists who wanted him to basically go away.

11 Q. Okay. But are you saying that
12 there was no change in the criteria listed in
13 the DSM between the change from gender identity
14 disorder to gender dysphoria?

15 A. It's all wording. I mean it's the
16 same entity. It's just his described -- and I
17 can't remember word for word what was in
18 DSM-III. DSM-IV I haven't referred to
19 recently, because DSM-5 is sort of the new
20 entity that we have
21 to -- like it or not, it's what's in there.
22 And so I have read, you know, the DSM-5
23 criteria and more familiar with them than I am
24 the prior ones.

25 But the idea is that it's -- you

1 know, it describes the same thing. It's just
2 named differently, so that it wasn't
3 pathologic. So that it was not a delusional
4 disorder. Zucker believed and stated that
5 gender identity and gender incongruence is a
6 delusional state. Period.

7 Q. Do you agree with that?

8 A. Yes, I do.

9 Q. Okay.

10 A. But it is not a delusional
11 disorder, and I didn't understand the
12 difference between the two of those things, but
13 he explained that sort of indirectly through a
14 third party that a delusional disorder is a
15 very specific psychiatric term and to say that
16 all kids with gender identity disorder are
17 delusional is incorrect. The only people that
18 are delusional are the adults who persist in
19 their delusion, and that becomes a delusional
20 disorder.

21 So all people who go through all
22 the counseling and therapy who do not lose that
23 delusional thought process then have a
24 delusional disorder. Period. End of sentence.
25 That's his -- he's the professional. I am not.

1 He's the one who published and treated, and so
2 I defer to experts in that field to use the
3 terminology that they choose. But making
4 gender dysphoria the terms took it away from
5 being a disorder, and that was the entire
6 purpose of the APA committee that did that.

7 And there are people who are a
8 party to the discussions that occurred both
9 with Zucker in the room and with him out of the
10 room about how they were going to essentially
11 push him into dropping the disorder.

12 Q. Okay.

13 A. And he thought that would be a
14 disservice to the patients, that they would end
15 up on the streets with no --

16 Q. Okay. So just to be clear so I
17 understand Zucker. Children lower than the age
18 of majority, who have what would be called now
19 gender dysphoria, then gender identity
20 disorder, have a term you used called the
21 delusional state, correct?

22 A. Correct.

23 Q. And do you agree with that?

24 A. Delusional thought. I want to
25 retract the word state. Delusional thought.

1 Q. Okay. And then adult people over
2 the age of majority or at the age of majority,
3 who have gender dysphoria or gender identity
4 disorder as it was formerly called and
5 therefore persist with that have a delusional
6 disorder?

7 A. Yes. That was the original
8 statement.

9 Q. Okay.

10 A. But the word disorder was taken
11 away.

12 Q. But do you agree with that?

13 A. I do. I agree with that.

14 Q. Okay. So this first critique here
15 says that the GID criteria were different in
16 kind in some ways than the gender dysphoria,
17 and that could explain some difference in prior
18 results from studies today. And you disagree
19 with that?

20 MR. BLAKE: Objection.

21 THE WITNESS: I do.

22 BY MS. INGELHART:

23 Q. Okay. And then the second
24 criticism here is about follow-up after the
25 fact. Do you happen to know Dr. Zucker's

1 methodology and how long after this study was
2 completed that he did the follow-up?

3 A. He followed all the patients
4 through adulthood. He was not limited to just
5 children.

6 Q. Okay.

7 A. His clinic was addiction medicine.
8 That was the subdivision. So he took care of
9 primarily adults, but this was a very small
10 subset of patients who happened to be children.

11 Q. Okay. Do you know how far into
12 adulthood that he followed them?

13 A. I don't.

14 Q. All right. I think we're going to
15 look at another exhibit, but just kind of
16 quickly. So you can set this aside.

17 (Thereupon, Plaintiffs' Exhibit 3,
18 a developmental, biopsychosocial model for the
19 Treatment of Children with Gender Identity
20 Disorder, was marked for identification
21 purposes.)

22 BY MS. INGELHART:

23 Q. Okay. So do you recognize this
24 document?

25 A. I do.

1 Q. What is it?

2 A. It's Kenneth Zucker's compendium
3 of his experience with the patients in his
4 clinic.

5 Q. Is this the study you were
6 referring to when you were making references
7 about rates of desistance among gender disorder
8 children?

9 A. I can't remember if he
10 specifically looks at rates of desistance in
11 this article or it's a parallel publication,
12 but he looks at the methodology and the
13 undercurrent issues, the emotional issues and
14 how this happens, why it happens, and what one
15 can do. And it has a lot of case studies in it
16 to kind of give examples of typical things,
17 and, you know, why it develops, when it
18 develops, how it goes through the child's life
19 and what his recommendations would be in terms
20 of helping these children to the best of his
21 ability.

22 Q. Okay. If you turn to Page 392,
23 it's a continuation of a section that starts
24 actually on 391, which is titled, is prevention
25 of adult transsexualism a reasonable treatment

1 goal, and given the low frequency with which
2 GID persists into adulthood, how is it possible
3 to determine the efficacy of treatment in
4 attaining that goal?

5 So the bottom of Page 392, that's
6 what is being discussed is the desistance. Can
7 you read out the last full paragraph at the
8 bottom of 392?

9 A. The guest editors have made
10 reference to the low frequency with which GID
11 persists into adulthood and the implications of
12 this fact in the evaluation of treatment
13 efficacy. Persistence rates have varied fairly
14 substantially in long-term follow-up studies.
15 For example, Green reported that only 1 of 44
16 previously feminine boys appeared to be gender
17 dysphoric at the time of follow-up. In
18 contrast, Wallien and Cohen-Kettenis reported
19 that 50 percent of 18 GID girls were persisters
20 at follow-up. In our own follow-up studies, we
21 found a persistence rate of 12 percent for GID
22 girls and persistence rate of 13 for GID boys.
23 Thus, there is a fair bit of variation in
24 persistence rates.

25 Q. Okay. Could you read on to the

1 paragraph that tracks between the two pages
2 there?

3 A. How can this variation be
4 understood? One possibility is sampling
5 differences. Another possibility pertains to
6 the degree of GID in childhood. Both Wallien
7 and Cohen-Kettenis and Singh showed several
8 metrics of GID severity in childhood predicted
9 persistence at follow-up. Other possibility is
10 to contextualize the natural history data. Is
11 there really such a thing as natural history
12 for GID or does its developmental course vary
13 as a function of contextual factors? If, as in
14 our clinic, treatment is recommended to reduce
15 the likelihood of GID persistence, perhaps the
16 data can only be interpreted in that context.
17 In any event, we require more comparative data
18 to draw conclusions about the natural history
19 of GID in children and its relation to
20 contextual factors.

21 Q. Thank you. So the first paragraph
22 you read on Page 392 referred to a few studies
23 with varying rates of reported desistance,
24 correct?

25 A. Yes.

1 Q. Okay. So there is difference in
2 studies about desistance rates?

3 A. There are, but the majority of
4 them show a higher rate than the 50 percent in
5 the one study of girls that Wallien and
6 Cohen-Kettenis says. Again, it looks as if --
7 and I haven't asked him why he put this in this
8 particular paper -- that he chose one that
9 showed a relatively low, 50 percent, and then
10 his which showed 80 and essentially 90, 88
11 percent and 80 percent in his.

12 The actual data that are in the
13 DSM-5 come from a coalescence of all the
14 studies.

15 Q. Okay.

16 A. Not just these two, what he
17 called, extremes. He called his a high rate of
18 desistance and Wallien and Cohen-Kettenis a
19 relatively lower. But still 50 percent is not
20 something to sneeze at, and he just chose those
21 two as ends. In terms of what the DSM-5
22 criteria say, 98 percent of boys and 88 percent
23 of girls is the most that's been reported, not
24 by Zucker or that other person.

25 Q. Okay. And then, you know,

1 throughout the paragraphs we were reading it
2 refers to GID, or gender identity disorder,
3 right?

4 A. Right.

5 Q. Okay. And if we turn to the very
6 first page, just the front cover, yours looks
7 different than mine. Does it have the
8 publication date? It does. What is that
9 publication date?

10 A. That says 2012, I think. Yes. I
11 believe it's -- all right. Yeah. March 2012.

12 Q. Great. Okay. And when was the
13 DSM-5 first published?

14 A. I don't know. I'm guessing 2014.
15 I think that's about right.

16 Q. I think that's close. So it was
17 after this?

18 A. Yes.

19 Q. So that's why they referred to
20 GID?

21 A. Yeah.

22 Q. Okay. All right. Thank you.
23 You're also a member of the Endocrine Society,
24 you said?

25 A. Yes.

1 Q. Okay. Are you aware of whether
2 they have a position statement about the
3 treatment of transgender folks?

4 A. They did their clinical
5 guidelines.

6 Q. Okay.

7 A. In 2009 and then the revision in
8 2017.

9 Q. Okay. Then you said that was a
10 society that's selective in such a way that it
11 requires training in the field of pediatrics?

12 A. You know, I'd have to say you pay
13 dues, and you're in a category depending on
14 your degree.

15 Q. Okay. So let's look at that
16 position statement too.

17 (Thereupon, Plaintiffs' Exhibit 4,
18 transgender health, was marked for
19 identification purposes.)

20 BY MS. INGELHART:

21 Q. Okay. Have you seen this before?

22 A. Yes.

23 Q. And what is it again?

24 A. This is the Endocrine Society
25 guidelines. It's a position statement, and I

1 don't know whether or not this is the 2000 --
2 yeah, it's the 2017. So it's the second
3 attenuation of this guideline.

4 Q. Okay. And looking at the second
5 paragraph on the first page, the first
6 paragraph under the word background, do you see
7 the last full sentence of that paragraph which
8 begins with the word considerable?

9 A. Okay. Do you want me to read that
10 to you?

11 Q. Sure.

12 A. I'll just read it, okay.

13 Q. Do you disagree with that
14 statement?

15 A. Considerable scientific evidence
16 has emerged demonstrating a durable biologic
17 element. I totally disagree with that.

18 Q. Okay. And on what basis do you
19 disagree with that?

20 A. There is no scientific basis for
21 that whatsoever.

22 Q. Okay.

23 A. And it's so stated in the DSM
24 criteria and the APA handbook.

25 Q. Okay. Yes. I think you said

1 that. So in both of those documents they
2 state, according to you, that there's no
3 biological basis, correct?

4 A. That's correct.

5 Q. Okay. So can you see the I guess
6 second half of that sentence, or maybe it's a
7 whole new sentence, individuals may make
8 choices?

9 A. Individuals make choices due to
10 other factors in their lives, but there do not
11 seem to be external forces that genuinely cause
12 individuals to change gender identity.

13 That's also totally not factual.

14 Q. And on what basis do you say that?

15 A. On the basis that 70 percent of
16 kids are reported to have -- no. Excuse me.
17 40 percent of kids are reported to have
18 undercurrent psychological morbidity.

19 Q. Okay. So I do want to make a
20 distinction. So you're a pediatric
21 endocrinologist, right?

22 A. Yes.

23 Q. And Dr. Zucker's also a pediatric
24 endocrinologist, correct?

25 A. No. He's a clinical psychologist.

1 Q. He's not a pediatric
2 endocrinologist?

3 A. No, he is not.

4 Q. Okay. We'll come back to that.
5 We'll just have to come back to that. Okay.
6 And then if we flip this over, it looks at
7 positions. Do you see the second bullet point
8 under positions?

9 A. Medical intervention for
10 transgender individuals, including both hormone
11 therapy and medically indicated surgery is
12 effective, relatively safe, and has been
13 established as the standard of care.

14 Q. Do you disagree with that
15 statement?

16 A. Yes, I disagree with that. I
17 would say established as standard of care is
18 this document establishes a guideline but not a
19 standard of care. The WPATH is the standard of
20 care.

21 Q. Okay.

22 A. And I would argue that they are --
23 that (A), it is not relatively safe at all, and
24 has been established as the standard of care.
25 That's the WPATH's standard of care. It's a

1 self-serving social advocacy organization of
2 people who believe that's correct, and they all
3 believe it.

4 Q. What makes WPATH a self-serving
5 social advocacy organization?

6 A. It has no requirement for
7 education, certification or training.

8 Q. Would it surprise you to know that
9 they do have a certification for training?

10 A. Oh, they will do a certification,
11 if you attend a conference. But it's not
12 required for membership. Membership requires
13 paying dues. That's it.

14 Q. What is required of membership for
15 the American College of Pediatrics?

16 A. Board certification in pediatrics.

17 Q. And WPATH doesn't require any type
18 of board certification?

19 A. Does not require it. It is people
20 who are interested in the field of transgender
21 health.

22 Q. Okay.

23 A. And if I applied, they might
24 recognize my name and say, no, I can't become a
25 member. They are evidently trying to -- well,

1 I won't go into that.

2 Q. What about the American Diabetes
3 Association?

4 A. They're a professional section.
5 You have to have a degree certification.

6 Q. Do you need a degree certification
7 for the professional part of WPATH?

8 A. I didn't realize there was a
9 subsection that was professional only.

10 Q. Okay. Okay.

11 A. So I went to their website and
12 said, if I want to become a member, what
13 information do I have to provide? And degree
14 certification was absolutely not part of it.

15 Q. Okay. Well, very good. Let's put
16 this aside.

17 Okay. So are you a member of the
18 American College of Pediatrics?

19 A. American College of Pediatricians.

20 Q. Pediatricians.

21 A. Yes.

22 Q. I'm sorry.

23 A. Mm-hmm.

24 Q. Are you a leader within that
25 organization?

1 A. I'm currently the president.

2 Q. Okay. How long have you been a
3 member?

4 A. Since 2007.

5 Q. How long have you been the
6 president?

7 A. I assumed the position 13 months
8 ago.

9 Q. Okay. When was the American
10 College of Pediatricians formed?

11 A. I believe, 2002.

12 Q. Okay. Were you a part of that
13 formation?

14 A. No.

15 Q. Do you know what motivated the
16 founding group, founding members to formally
17 organize?

18 A. The American Academy of Pediatrics
19 produced a statement on the effects and
20 benefits of same sex adoption. In that policy
21 statement they essentially said there was
22 absolutely no adverse effect whatsoever of same
23 sex couples adopting children and that the
24 outcome of these children was as good, and
25 without statistically significant findings,

1 perhaps even better, based on anecdotal
2 reporting of welfare of the families that they
3 surveyed that these kids were maybe even
4 perhaps better cared for. But we can't prove
5 that scientifically, but certainly there is no
6 provable downside to same sex adoption.

7 Q. Okay.

8 A. And adoption is a very complex and
9 critical issue, and these members said, okay,
10 let's look at the scientific background. And
11 then Dr. Sharon Quick, who's a pediatric
12 intensivist, took the time and went through
13 point by point of all the technical paper that
14 supported and said, these are not valid
15 scientific studies. These are anecdotal
16 reports. These are things that were basically
17 a survey from the LGB community. Have you
18 adopted? How happy are your children? Okay?

19 And so it wasn't done
20 independently and professionally. These were
21 just report after report after report, and they
22 were trying to, therefore, ergo, these kids are
23 very happy and very functional and without any
24 difference whatsoever and anecdotally maybe
25 even better, because they were, you know --

1 just a better environment in their opinion.

2 And so they took issue with that,
3 and they tried to speak within the academy. A
4 former president of the American Academy
5 himself, Joe Zanga, took strong issue as a
6 member of the executive committee of past
7 presidents and an invited person, and he
8 realized where this came from.

9 Q. Okay.

10 A. And he knew the inside workings of
11 the academy, of the committee that generated
12 this report and said it's unethical what they
13 did, and this is not the American Academy of
14 Pediatrics that it's supposed to be. We are
15 off the track. They've gone off the wheels
16 here. We need to speak with what is
17 scientifically valid for children.

18 And it was at that point that he
19 and a couple of other members at a meeting of
20 the AAP actually gathered together in a sidebar
21 meeting room and said, what can we do about
22 this? And Joe specifically said there is no
23 way for us to change this position statement.
24 He knew how the position statement was put
25 together. He knew that it did not represent a

1 vote as a membership, that it was not with any
2 input from the vote of the majority of the
3 membership, that it was done by a committee.
4 And he knew those members individually, and he
5 said they are agenda oriented people. They are
6 misstating science, and the American Academy
7 can't tolerate this. He was told, sorry,
8 Charlie. You know, you don't like it, tough.

9 He did not leave them. He to this
10 day has not left the American Academy of
11 Pediatrics. He's a stalwart that says, if
12 we're going to bring about change and rescue
13 the AAP, we have to stay within it and work
14 within it. Okay?

15 Q. Mm-hmm.

16 A. But he has made no headway
17 whatsoever in that regard. He encouraged me
18 all the way through to stay a member of the AAP
19 for the same purpose. He said if everyone who
20 disagrees and is really disgusted with the AAP
21 leaves, the AAP will get more and more down
22 that pathway, and children will be harmed,
23 because everybody looks to the AAP. It's
24 giant. It's huge. It was essentially the only
25 general pediatric, you know, advocacy group.

1 And so he stuck with it, but a
2 number of individuals said no, and he was one
3 of the founding members of the American College
4 for that specific purpose. Not casting
5 aspersions and name calling and hating and
6 being bigoted and awful, but basically saying
7 kids are who we're supposed to represent here.
8 What's happened is that we have left the
9 benefit for children, and we've gone off for
10 the wants and needs of the adults.

11 Q. Okay.

12 A. And that's how it was started.

13 Q. Okay. So let's look at another
14 exhibit.

15 (Thereupon, Plaintiffs' Exhibit 5,
16 Pro-Life Pediatric Group Stands Contrary to
17 Established American Academy of Pediatrics, was
18 marked for identification purposes.)

19 BY MS. INGELHART:

20 Q. What I just had marked as
21 Plaintiffs' Exhibit No. 5 is an article from
22 the publication called the Catholic Exchange.
23 It's about the founding of the American College
24 of Pediatricians. On the second page, Zanga,
25 Dr. Zanga, as you were speaking of before, is

1 quoted as describing his organization -- or not
2 quoted. He's referenced as describing his
3 organization as one with Judeo-Christian,
4 traditional values that's open to pediatric
5 medical professionals of all religions who hold
6 true to the group's core beliefs, that life
7 begins at conception and that the traditional
8 family unit, headed by an opposite-sex couple,
9 poses fewer risk factors in the adoption and
10 raising of children. Is that accurate?

11 A. That's Dr. Zanga's opinion, okay?
12 In terms of Judeo. It happens that
13 Judeo-Christian concepts happen to jibe with
14 the concept of what is best for children and
15 keeping politics out of that. You know,
16 focusing on truly a core value that is ethical
17 and based on science. And so life begins at
18 conception is a scientifically valid opinion.
19 It's proven in any number of ways, but people
20 have opposite opinions. Okay? So that happens
21 to jibe with Judeo-Christian, and in this case
22 Catholic theology. So they report on that as
23 if that's the core, and this is a religious
24 based organization.

25 There is absolutely no requirement

1 to be of any particular religious faith at all
2 in membership. It's not asked for. It is
3 discussed among members collegially, if they
4 wish to share that information, but the
5 organization is completely devoid of a
6 religious basis. There is nowhere in the
7 application -- no one is excluded for being an
8 atheist or any religion other than
9 Judeo-Christian religions.

10 Q. Okay. Why did you join ACP?

11 A. Because I knew Joe Zanga
12 personally, and he asked me if I knew about the
13 organization and he said, would you become a
14 member? Because he knew of my advocacy with
15 the Georgia Chapter. He was in Columbus,
16 Georgia at the time and head of Columbus
17 Regional Medical Center's Pediatric Department,
18 and so he invited me down for CME.

19 I knew him from medical school
20 days. He was a resident a couple years ahead
21 of me in the -- a medical student a couple
22 years ahead of me and in the residency program
23 at Medical College Virginia. He also happened
24 to intersect with my wife and my brother, who's
25 an emergency room specialist in New Orleans,

1 and Joe was in New Orleans at the Children's
2 Hospital there as head of pediatrics for a
3 while and ran into my brother and said, do you
4 know -- not a very common last name.

5 And so our paths kept crossing,
6 and so he took the time to write me and said,
7 would you look into what our organization is?
8 And I did, and I thought this makes a lot of
9 sense, and it's exactly why I'm frustrated with
10 the direction the AAP is going, why I love the
11 Georgia Chapter, because they are far more
12 tuned into helping children and avoiding
13 political traps and working across the aisle
14 and getting state legislatures to understand
15 true science and benefit for children. So I
16 joined.

17 Q. Okay. Thank you. I'd like to
18 talk a little bit more about the group. I'm
19 going to enter another exhibit. I'm definitely
20 going to lose count.

21 THE COURT REPORTER: This is No.
22 6.

23 MS. INGELHART: Thank you.

24 (Thereupon, Plaintiffs' Exhibit 6,
25 About Us, American College of Pediatrics, was

1 marked for identification purposes.)

2 BY MS. INGELHART:

3 Q. Do you recognize this document,
4 this webpage?

5 A. I do.

6 Q. Can you tell me what it is?

7 A. It's sort of the mission statement
8 explanation of what the college is about. It's
9 from the website.

10 Q. Okay. So I want to start looking
11 at the core values portion, the heading that
12 falls at the bottom of the first page, but the
13 text is actually if we flip over to the second
14 page. No. 2, under core values says -- I
15 assume the subject would be the American
16 College of Pediatricians -- recognizes that
17 good medical science cannot exist in a moral
18 vacuum and pledges to promote such science.
19 What does that mean?

20 A. It means that ethics and a code of
21 behavior, of ethical behavior, which is the
22 basis of a civil society, has to be part of
23 that or we are in a vacuum that basically
24 allows for an anarchy of ideas, and that's what
25 it's about.

1 Q. Okay. So to your knowledge, is
2 there a reason that ethics wasn't used here
3 instead of referencing a moral vacuum?

4 A. I think they tried to use a term
5 that people would understand, and ethics is
6 perhaps not -- I didn't write this particular
7 thing. I read that, and I see ethics.

8 Q. Okay. The next one, No. 3,
9 recognizes the fundamental mother-father family
10 unit, within the context of marriage, to be the
11 optimal setting for the development and
12 nurturing of children and pledges to promote
13 this unit.

14 A. Yes.

15 Q. So this is a core value of the
16 ACP?

17 A. Yes.

18 Q. Okay. So when you say that
19 science can exist in a moral vacuum, is the
20 belief about the optimal setting for the
21 development of children based on a moral
22 principle?

23 A. No. It's based on sociology
24 research.

25 Q. Okay. And --

1 A. That's the science part.

2 Q. Okay. If science research showed
3 that children actually developed better with
4 two mothers, would that cause ACP to alter its
5 position?

6 MR. BLAKE: objection.
7 Hypothetical.

8 THE WITNESS: No.

9 BY MS. INGELHART:

10 Q. Why not?

11 A. Because if it's scientifically
12 valid, that's what the college is based on.

13 Q. Okay. So it would change its
14 position? I'm sorry. I think you --

15 A. Yeah. It would say that that was
16 not a critical part of welfare of children. If
17 a sociologic study, cross-sectional, not
18 picking volunteer people to say that I'm a same
19 sex couple and what do I think about my
20 children. If it was a total survey as the
21 sociologic studies that support the
22 mother-father intact unit family, if it's the
23 same quality and it comes up and says there is
24 no difference, then we would remove that
25 objection.

1 Q. I see. Okay. Do you agree with
2 this statement at No. 3, with the core value to
3 promote the unit of the mother-father family
4 unit?

5 A. Yes.

6 Q. Do you also agree with the No. 2
7 statement about medical science shouldn't exist
8 in a moral vacuum?

9 A. And when I refer to moral vacuum
10 as an ethicless vacuum, yes.

11 Q. Okay. So history section of this
12 webpage begins at the bottom of the page that
13 we're on. It says that ACP was founded --
14 let's see if I can find it. In Sentence 2
15 under history, it says that ACP was founded by
16 a group of concerned physicians who saw the
17 need for a pediatric organization that would
18 not be influenced by politically driven
19 pronouncements of the day.

20 A. Yes.

21 Q. Can you explain again what that's
22 referring to?

23 A. Yes. That was the statement on
24 same sex adoption. That's the document that
25 they were concerned about.

1 Q. Okay. But did you say in a prior
2 statement that same sex adoption isn't harmful,
3 it turns out? Is that what you said before?

4 A. No. That it was not as
5 beneficial. That the most beneficial is a
6 heterosexual, married, intact, functional
7 family.

8 Q. All right. Thank you. Okay. The
9 third sentence says, the college bases its
10 policies and positions upon scientific truth
11 within a framework of ethical absolutes. Not
12 to belabor, but can you explain what that
13 means?

14 A. It looks at sort of ethics as an
15 issue. It does not separate out ethics,
16 bioethics, and so you have issues of life and
17 death that you have to consider in terms of
18 interventions and policies and look at the
19 clinical research. And it's through that lens.
20 So for that reason, very naturally, it's going
21 to look at life at the beginning and life at
22 the end. And life at the end for pediatric
23 practice is situations where a terminal illness
24 is occurring, and what kind of support would
25 you give? Would you withdraw support? Is that

1 ethical?

2 And it takes a stand of ethics on
3 the side of, you know, life is precious, and
4 you really need to totally examine the ethical
5 issues with somebody independent, in the field
6 of bioethics, if necessary. And we have
7 consultants in those fields to look at and
8 critically review policy statements and through
9 their eyes.

10 Q. Okay. Thank you. Could you
11 define specifically what ethical absolutes
12 mean? Maybe you have, but I just...

13 A. I mean I didn't choose those
14 words. Okay? This is crafted by other people
15 who edit, but I think it's talking about you
16 can't ignore ethical issues, that you have to
17 take -- there is a limit which needs to be
18 established of what is ethical, and that if you
19 don't do that you could take science to a
20 harmful end.

21 Q. Okay.

22 A. Experimentation on children. You
23 know. Yeah.

24 Q. That's an ethical absolute no?

25 A. Yeah. I mean if you're going

1 to -- let's do something and see what happens.

2 Q. Okay.

3 A. You know, without true informed
4 consent and knowledge of -- it's what guides
5 clinical research to this day. We were all
6 trained repeatedly and endlessly on good
7 clinical practices, and so all the clinical
8 research studies I do I have to have
9 certification. I didn't mention that, but I'm
10 certified in good clinical practices for
11 clinical research. So we have to know about
12 informed consent assent, that balanced
13 presentations, stopping criteria, independent
14 reviews, safety and all that. All those have
15 to be understood. We have to know who
16 regulates those things and why they're
17 important. So that's where that comes from.

18 Q. Okay. So I guess if -- I'm just
19 trying to understand these terms. If there was
20 a conflict between one of these ethical
21 absolutes and what the scientific research
22 would show, then would the ethical absolute
23 take precedent?

24 MR. BLAKE: Objection.

25 Hypothetical.

1 THE WITNESS: I'll give you an
2 example. Let's just say that the science said
3 that if you poisoned children, a hundred
4 percent of them come to harm, that would be an
5 ethical issue that we'd say, no, you can't do
6 that study. Yes, it's a conclusion that might
7 be valid based on a scientific study that you
8 poisoned a hundred children and a hundred
9 children had very adverse -- and the majority
10 of them, 90 percent, died. Okay? That's valid
11 science.

12 BY MS. INGELHART:

13 Q. Okay.

14 A. Okay. It's not ethical.

15 Q. Got it. Okay. Another exhibit to
16 be introduced.

17 (Thereupon, Plaintiffs' Exhibit 7,
18 Gender Ideology Harms Children, was marked for
19 identification purposes.)

20 BY MS. INGELHART:

21 Q. So this is Plaintiffs' Exhibit No.
22 7. Do you recognize this document?

23 A. I do.

24 Q. Could you tell me what it is?

25 A. It's a statement by the college in

1 regard to the gender ideology, referring to the
2 sort of societal push to promote affirmation of
3 incongruent genders.

4 Q. Okay. The first sentence here
5 under the updated date, do you agree with that
6 statement there?

7 A. Yes, I do.

8 Q. Okay. Would you read it?

9 A. The American College of
10 Pediatricians urges healthcare professionals,
11 educators and legislators to reject all
12 policies that condition children to accept as
13 normal a life of chemical and surgical
14 impersonation of the opposite sex.

15 Q. What does impersonation of the
16 opposite sex mean?

17 A. It means the physical appearance
18 and -- the physical appearance, primarily, and
19 living as if they were the biologic opposite
20 sex.

21 Q. But specifically the word
22 impersonation, like what's that word doing?

23 A. That means that they are
24 pretending to be the opposite sex, when they
25 cannot be the opposite sex.

1 Q. Okay. Thank you. Turning over to
2 paragraph numbered 8, could you read the bold
3 sentence?

4 A. Conditioning children into
5 believing a lifetime of chemical and surgical
6 impersonation of the opposite sex is normal and
7 healthful is child abuse.

8 Q. And do you agree with that?

9 A. I thoroughly agree with that.

10 Q. And then there's a paragraph
11 called bottom line, which starts at the bottom
12 of the second page and continues over onto the
13 third page. So looking at the third page, the
14 last sentence says, the college maintains it's
15 abusive to promote this ideology, first and
16 foremost for the well-being of the gender
17 dysphoric children themselves, and secondly,
18 for all of their non-gender-discordant peers,
19 many of whom will subsequently question their
20 own gender identity, and face violations of
21 their right to bodily privacy and safety. Do
22 you agree with that statement?

23 A. Yes.

24 Q. Okay. What does it mean that
25 non-gender-discordant peers would subsequently

1 question their own gender identity in the
2 presence of gender dysphoric children
3 expressing --

4 A. Well, the precepts of childhood
5 development from Ericson and others who are
6 experts in that field, and all I know is what
7 we learned as pediatricians about how children
8 develop and what their concept is of abstract
9 principles and what their brains can figure
10 out, is a six-year-old, in general, who sees a
11 boy go leave the room and come back in with a
12 wig, makeup, eye lashes, a dress, and Mary
13 Janes, believe that it's possible that that
14 child changed from one sex to the other. Okay?
15 And that's concrete thinking. Okay? They
16 don't look at it as if it is a costume that
17 they're wearing. It's that that person
18 changed. And that's sort of the mindset of a
19 six-year-old. A nine or ten-year-old has a
20 little bit of a different world view than a
21 16-year-old and a 20-year-old.

22 And so that if you are in a school
23 environment, in kindergarten, and anxiety
24 develops when there is conflict in reality and
25 fantasy. You know, the scary stories and the

1 boogeyman in the closet and the monsters, et
2 cetera, et cetera, all come from a crossover
3 between not knowing what's real and not knowing
4 what's fantasy. And unless the child knows
5 real and fantasy, they begin to internalize
6 this concept and become anxious, and it
7 develops into an anxiety disorder as a result
8 of that.

9 So it's very important for
10 children to be taught concrete facts and to say
11 this is the pretend over here, and this is the
12 real over here. And when a kindergartner, a
13 five or six-year-old child, has a person in
14 their class suddenly turn into somebody of the
15 opposite sex, their fear is that will happen to
16 me. And there are any number of case reports
17 of that happening to children and them seeking
18 mental healthcare as a result of anxiety,
19 because they felt what I thought was real is
20 not real, where is reality, where is fantasy,
21 and is that going to happen to me? And so they
22 suffer, okay, as a result of that happening to
23 them.

24 Q. Are those case studies published?

25 A. Yes.

1 Q. Could I look at them?

2 A. Yes.

3 Q. Do you know who --

4 A. I don't know who published them,
5 but I know they have been. I've been referred
6 to. I actually am involved in a case in
7 England where two boys suffered emotionally
8 from anxiety disorder as a result of that and
9 required treatment.

10 Q. What's that case in England?

11 A. Salley and Nigel Rowe Versus
12 whatever. City of Isle of White or something.

13 Q. Is that because I think I read in
14 England they've banded what's so-called
15 conversion therapy? Is it a related matter to
16 that new policy?

17 A. No. It was just a school policy
18 that said acceptance of transgender students
19 will happen, and that it's going to happen.

20 Q. Got it.

21 A. Yeah.

22 Q. Okay. The questioning of their
23 own gender identity of -- just gender
24 identified or nontransgendered children, as a
25 result of seeing other children transition, is

1 that an example of that social contagion
2 principle we were talking about before?

3 A. No.

4 Q. Oh, okay. Can you explain the
5 difference then?

6 A. So social contagion is sort of a
7 person who has anxiety and depression, who
8 talks to friends, goes to a meeting of issues
9 related to transgender and same sex attraction,
10 is introduced to the concept or is told by a
11 teacher, as is the cases in British Columbia,
12 that they are transgender. They don't
13 understand what transgender is. They go to the
14 internet, and they see, and it's like a
15 checklist.

16 I always say it's like the ADD
17 checklist on the front of Good Housekeeping
18 magazine at the grocery store. If I go down
19 that list, I have severe ADD based on just
20 checking off a list of things that says this is
21 how you establish the diagnosis. When in truth
22 that's not valid at all.

23 Q. Okay.

24 A. So these kids don't have that
25 level of sophistication, and when they're

1 troubled and they go to the internet and
2 someone has told them, go here and look here, I
3 think that's what you have, they'll go down a
4 checklist. And by gosh they match the
5 criteria; therefore, that is me. And then they
6 start communicating online with others, and
7 they say, yes. Those people say, come on over.
8 This is exactly what you have. You need to.
9 This is the answer to your prayers. And that's
10 the recruitment of those kids.

11 Q. Okay.

12 A. It's different than being affected
13 by -- you know, and having anxiety as a
14 young -- and these are young children. You
15 know, a 12 or a 13-year-old knows better. I
16 mean this is a child who's suffering. You
17 know, I want to have compassion for them. My
18 school tells me we should have compassion. We
19 should not bully them. It's wrong to say
20 anything negative to them or to harm them
21 emotionally in any way, which is totally valid,
22 totally compassionate, totally supported by our
23 organization or my professional opinion. But,
24 you know, those kids know that this is that
25 child, and this is not me. I will not fear

1 that that is going to happen to me.

2 Q. That's what you mean by know
3 better?

4 A. Yes.

5 Q. Okay. And so the comments in this
6 most recent exhibit about children questioning
7 their gender identity is about young children?

8 A. About young children.

9 Q. With different cognitive abilities
10 than the type of people who are susceptible to
11 the social contagion pressures?

12 A. That's correct.

13 Q. Got it. Thanks.

14 MS. INGELHART: I have just this
15 many more, but we could pause if people are
16 hungry.

17 THE WITNESS: I'm fine.

18 MR. BLAKE: Let's finish this --

19 THE WITNESS: Let's get through.

20 MR. BLAKE: -- module.

21 (Thereupon, Plaintiffs' Exhibit 8,
22 On the Promotion of Homosexuality in the
23 Schools, was marked for identification
24 purposes.)

25 BY MS. INGELHART:

1 Q. I just placed in front you, or had
2 placed in front of you, Plaintiffs' Exhibit No.
3 8. Do you recognize this documents?

4 A. I do.

5 Q. What is it?

6 A. This is a statement by the college
7 in August of 2008 that was produced after the
8 letter to superintendents of schools by the
9 Obama administration, which promoted the
10 concept that there was absolutely no negativity
11 whatsoever to the homosexual lifestyle and
12 conditions that are medical conditions
13 associated with that particular diagnostic
14 criteria or lifestyle.

15 Q. Okay. Thank you. That's helpful
16 context. The checklist on the right column,
17 the fourth one down that says homosexual
18 lifestyle carries grave health risks.

19 MR. BLAKE: I'm just going to
20 object to this entire exhibit as entirely
21 irrelevant. It's not related to transgender
22 folks at all. It's not a document which he's
23 said he's relied on to form his opinion, but if
24 you want to waste your time and ask more
25 questions about this --

1 THE WITNESS: Well, I mean I don't
2 see what it has to do with transgenderism. So
3 but if I could just say that.

4 BY MS. INGELHART:

5 Q. Okay. I guess I appreciate that.
6 I'm just going to ask a couple of questions.
7 So these two checkmarks here, the fourth and
8 the fifth, do you disagree with those
9 statements?

10 MR. BLAKE: Objection.

11 THE WITNESS: The scientific
12 evidence that I know of indicates that those
13 are issues, and then actually Dr. McHugh and
14 Mayer's treatise on this subject, it's
15 documented as such.

16 BY MS. INGELHART:

17 Q. Okay. Does the mainstream medical
18 establishment agree that the sexual
19 reorientation therapy mentioned here is
20 effective?

21 MR. BLAKE: Objection. Vague.

22 THE WITNESS: It depends on -- the
23 sexual reorganization therapy I think is not
24 something that is supported. What is called
25 integrative therapy or talk therapy for anxiety

1 and depression is supported. Okay?

2 BY MS. INGELHART:

3 Q. Is that distinction similar to
4 what we made before about how conversion
5 therapy for some is -- that people have
6 different meanings for the word conversion
7 therapy?

8 A. Absolutely.

9 Q. Okay. So some might read the word
10 sexual orientation and imagine something
11 extreme?

12 A. That's correct.

13 Q. Involving like physical
14 interaction?

15 A. Correct.

16 Q. And some may read it as talk
17 therapy?

18 A. That's correct.

19 Q. Okay. Thanks. That's all on that
20 one. And then I'm going to switch forward to
21 this one.

22 While we're looking for that, do
23 you believe that talk therapy can have similar
24 effects for people who have same sex attraction
25 as people who are gender dysphoric?

1 MR. BLAKE: Objection. Relevance.

2 THE WITNESS: The talk therapy is
3 all aimed at the undercurrent anxiety,
4 depression, related to ACEC, adverse childhood
5 events. And so there's a common thread that
6 when that is the core issue that talk therapy
7 works in both instances.

8 BY MS. INGELHART:

9 Q. Okay. So in the case of same sex
10 attraction it works to address underlying
11 concerns and therefore change sexual behavior?

12 MR. BLAKE: Objection. Relevant.

13 THE WITNESS: The goal is not to
14 change sexual behavior. It's to basically
15 address the undercurrent anxiety and
16 depression, so that you don't have suicide and
17 debilitating depression ongoing, because it's
18 not going to be paid attention to.

19 BY MS. INGELHART:

20 Q. Okay. So we have a new exhibit
21 here.

22 (Thereupon, Plaintiffs' Exhibit 9,
23 American College of Pediatricians, The Best for
24 Children, was marked for identification
25 purposes.)

1 BY MS. INGELHART:

2 Q. Do you recognize this document?

3 A. I do.

4 Q. To whom was it addressed?

5 A. To school superintendents.

6 Q. Is it similarly broadly addressed
7 to the Obama letter where this was sent to more
8 than one or could be sent to more than one
9 school district?

10 A. Yes.

11 Q. Okay. Does this document
12 reflect, specifically turning over to the
13 second and third paragraphs here -- okay.
14 Let's be more specific here. Looking past the
15 colon in the second paragraph to (1)
16 individuals with unwanted same sex attraction
17 often can be successfully treated, does ACPs
18 agree with that statement?

19 MR. BLAKE: Objection. Relevance
20 again. This is another document that at least
21 in part deals solely with same sex issues and
22 doesn't relate to transgender issues or Dr. Van
23 Meter's opinion.

24 Go ahead. You can answer.

25 THE WITNESS: The concept here is

1 that if an individual is suffering, that to
2 deny them therapy that could be beneficial is
3 harmful.

4 BY MS. INGELHART:

5 Q. And how are you characterizing a
6 denial of treatment?

7 A. By law.

8 Q. And what laws? I'm sorry.

9 A. State laws, in California. I
10 think there are 14 states and the District of
11 Columbia which outlaw any therapy for people
12 who have unwanted same sex attraction that are
13 seeking counseling.

14 Q. Okay. Seeking counseling to what
15 end?

16 A. To try to figure out why they're
17 unhappy with their sexual attraction, and they
18 would like to be relieved of that.

19 Q. Okay. And those are the same laws
20 that discuss similar treatment for people who
21 are gender dysphoric, right?

22 A. That's correct. It is now an
23 umbrella.

24 Q. Got it. Which is why these are
25 relevant. So are you familiar with those laws?

1 Those banned laws?

2 MR. BLAKE: Objection. Relevance,
3 again. I know you think this is relevant
4 because the same laws are involved, but these
5 laws are not part of this case or --

6 MS. INGELHART: I appreciate it --

7 MR. BLAKE: -- or.

8 MS. INGELHART: You can --

9 MR. BLAKE: Hold on please. Or
10 his opinion. I mean you've gone on now for
11 three or four hours. I guess it's only been --
12 well, it's almost four hours. About a lot of
13 things that tangentially relates to his
14 understanding of transgender issues and
15 potentially bias, but his opinion -- none of
16 his conclusions and his opinion have been
17 addressed once so far.

18 Go ahead. You can answer.

19 THE WITNESS: You probably need to
20 restate the question now.

21 MS. INGELHART: Yeah. Yeah.

22 MR. BLAKE: Same objection.

23 MS. INGELHART: And I appreciate
24 it. And so we can have that standing
25 objection, because I think I understand

1 counsel's position, and we're going to try to
2 move efficiently in the speaking objections.

3 If we can just have it as a standing
4 objections. If we can just have it as a
5 standing objection, we'll let it go faster.

6 BY MS. INGELHART:

7 Q. This first -- next to No. 1 --
8 individuals with unwanted same sex attraction
9 can often be successfully treated. That
10 implies that people with unwanted same sex
11 sexual attraction can often be treated and
12 therefore not have that same sexual attraction
13 anymore, correct?

14 MR. BLAKE: Objection.

15 THE WITNESS: It basically says
16 they can be treated for their undercurrent
17 depression and anxiety.

18 BY MS. INGELHART:

19 Q. Then why doesn't it say that?

20 MR. BLAKE: Objection.

21 MS. INGELHART: He's the president
22 of this organization. Presumably --

23 MR. BLAKE: Not in 2010.

24 THE WITNESS: I wasn't.

25 BY MS. INGELHART:

1 Q. This is still a position statement
2 that is on your website and accessible.

3 A. It is a letter to -- it was a
4 response to the Obama administration's treatise,
5 point by point.

6 Q. So do you no longer agree with
7 this statement?

8 A. We are in the process of revising
9 policy statements to be more germane and to
10 better express the intent, and so we are open
11 to critique of everything we've said. So that
12 it does not get misconstrued as to what our
13 intent was.

14 Q. Okay. But you previously
15 testified that you didn't disagree with this,
16 right?

17 A. Yes, I did.

18 Q. Okay. And this is still available
19 on your website?

20 A. Yes, it is.

21 Q. Okay. All right. Okay. The last
22 question. How many policy statements, about,
23 does the American College for Pediatricians
24 have?

25 MR. BLAKE: Objection. Relevance.

1 THE WITNESS: I would have to
2 guess. I don't know.

3 BY MS. INGELHART:

4 Q. Could you round for me?

5 A. 40.

6 Q. Okay. Do you know what proportion
7 reference LGBT related issues?

8 A. Probably, 50 percent.

9 MS. INGELHART: Okay. We can go
10 off the record and break for lunch.

11 (Thereupon, a break was taken.)

12 MS. INGELHART: Okay. We'll go
13 back on the record.

14 BY MS. INGELHART:

15 Q. Do you know whether transgender
16 people experience higher rates of
17 discrimination than the general population?

18 MR. BLAKE: Objection. Relevance.
19 Answer if you know.

20 THE WITNESS: No. I do not know.

21 BY MS. INGELHART:

22 Q. Do you know whether transgender
23 people experience higher rates of harassment
24 than the general population?

25 MR. BLAKE: Objection. Basis

1 foundation.

2 BY MS. INGELHART:

3 Q. Okay. Do you know whether
4 transgender people experience higher rates of
5 violence than the general population?

6 MR. BLAKE: Objection.

7 THE WITNESS: I do not. No.

8 BY MS. INGELHART:

9 Q. Do you know whether transgender
10 people may be exposed to immediate negative
11 outcomes, if they have to use identity
12 documents that reveal their transgender status?

13 A. I do not.

14 MR. BLAKE: Objection.

15 Foundation.

16 BY MS. INGELHART:

17 Q. What determines gender identity?

18 A. The individual.

19 Q. Can you explain?

20 A. Gender, as it was brought into
21 medical terminology by John Money, meant it's
22 sort of an internal sense of your sexual
23 identity.

24 Q. Okay. Okay. Are there any
25 components of gender identity, or how do you

1 know someone's gender identity.

2 MR. BLAKE: Objection. Vague.

3 THE WITNESS: You ask them.

4 MS. BONHAM: Is this all one
5 exhibit?

6 MS. INGELHART: It should be, but
7 we can triple check.

8 (Thereupon, Plaintiffs' Exhibit
9 10, letter, CV, and rebuttal expert report from
10 Dr. Van Meter, was marked for identification
11 purposes.)

12 BY MS. INGELHART:

13 Q. All right. What we've just
14 presented is Plaintiffs' Exhibit 10. For ease
15 of reference and flipping back and forth, we
16 have put your first report with your rebuttal.
17 So the order of the documents here is your
18 initial report, followed by your CV, followed
19 by your rebuttal report.

20 A. Okay.

21 Q. Thank you. So do you recognize
22 this document?

23 A. I do.

24 Q. Okay. And did you create this
25 document?

1 A. I did.

2 Q. Okay. And you reviewed it in
3 advance of today, correct?

4 A. Yes, I did.

5 Q. Okay.

6 A. Whether I reviewed this copy of my
7 CV, I can't tell you. It depends on the date
8 of it.

9 Q. Okay. So I want to turn to the
10 rebuttal report at the back, which Paragraph 11
11 of it is the second to last page of this pile
12 of papers.

13 A. Paragraph 11. Okay.

14 Q. Can you read Paragraph 11?

15 A. Yes. Dr. Ettner states elsewhere,
16 in Paragraph 20, that gender identity is
17 determined merely by the statement of the
18 adolescent or adult. Mere statements by the
19 individual, obviously, do not indicate a
20 biologic basis for gender identity. Nor do
21 such statements indicate that gender identity
22 is immutable.

23 Q. Okay. Did you just testify that
24 you determined somebody's gender identity by
25 asking them?

1 A. Gender identity, yes.

2 Q. Okay. So this Paragraph 11 here,
3 you're saying that you disagree with Dr. Ettner
4 as to substance in your second two sentences,
5 not the first?

6 A. I'm not sure I understand your
7 question.

8 Q. Sure. Okay. So in Paragraph 11
9 you state that -- you reference back to Dr.
10 Ettner's report where she says to you,
11 according to you, that gender identity is
12 determined merely by the statement of the
13 adolescent or adult?

14 A. That's correct. So I don't
15 disagree with that.

16 Q. Okay. So you're highlighting your
17 divergence from her opinion in the second two
18 sentences, correct?

19 A. That's correct.

20 Q. Okay. And what is your basis that
21 there's no biological basis for -- what's your
22 basis for the assertion that there's no
23 biological basis for gender identity?

24 A. Because there is no valid
25 scientific study that indicates such.

1 Q. Okay.

2 A. There are attempts to look at
3 brain MRI studies to look at exon deletions or
4 couplings and pairs. The numbers are extremely
5 small. The interpretation that is presented
6 has been challenged by authorities in the
7 fields of neuroimaging and in molecular
8 genetics to say that the conclusions that were
9 reached in each case that are not valid.

10 Q. Thank you. In your view, a
11 person's sex does not include their gender
12 identity, correct?

13 A. That's correct.

14 Q. In your professional expert
15 opinion, is a gender identity something that is
16 fixed?

17 A. No, I do not believe it's fixed.

18 Q. Okay.

19 A. But it may be persistent, but it
20 is not so that it cannot be changed.

21 Q. In your opinion, does gender
22 identity crystallize for individuals at a
23 certain point in time?

24 A. I do not know.

25 Q. Okay. Great. We'll put this

1 aside. We will certainly come back to it.

2 A. Okay.

3 Q. I'm going to introduce another
4 exhibit. Exhibit 11.

5 (Thereupon, Plaintiffs' Exhibit
6 11, Certification of Birth of Stacie Marie Ray,
7 was marked for identification purposes.)

8 BY MS. INGELHART:

9 Q. Plaintiffs' Exhibit 11 has just
10 been handed to you. Do you know what this
11 document is?

12 A. It says it's a certification of
13 birth

14 Q. From the State of Ohio, right?

15 A. From the State of Ohio.

16 Q. Do you happen to recognize the
17 name on this birth certificate?

18 A. Yes, I do.

19 Q. Do you know who it is?

20 A. It's one of the plaintiffs, I
21 believe.

22 Q. Okay. Great. Thank you. Looking
23 at the right-hand side of the birth certificate
24 where there's a field that says sex, does it
25 say biological sex or sex?

1 MR. BLAKE: Objection.

2 THE WITNESS: It says sex, because
3 biological sex is sort of a redundancy. Sex is
4 sex, and it is biologic. So you don't have to.
5 It's like saying it's a green color. Okay?
6 Sex is biologic. So to say biologic sex is to
7 try to separate it from the construction of
8 gender identity. So it has no biologic basis.
9 Sex and gender are often interchangeably used
10 on documents.

11 My Georgia driver's license has
12 sex. My Delta frequent flyer card has gender.
13 The reason for that I can only, in conjecture,
14 say is because the word sex has so many
15 connotations in terms of a verb, you know, it's
16 a potentially adult word of some kind, but
17 gender is so squeaky clean that it's an easier
18 way to say what you really mean, which is the
19 sex of the patient.

20 BY MS. INGELHART:

21 Q. Okay. So --

22 A. That's just --

23 Q. No, no.

24 A. I'm trying to figure it out. Why
25 in the world would you ever use gender on a

1 document if you're applying for something, when
2 what you're really trying to say what is your
3 sex?

4 Q. Okay. So do you think that
5 government issued identity documents should
6 just list sex assigned at birth instead of a
7 marker for gender?

8 A. No, I think it should just say
9 sex. Sex assigned at birth is kind of another
10 inaccuracy. Okay? Sex is determined at
11 conception.

12 Q. Okay.

13 A. Calling it assigned is sort of a
14 judgmental kind of a thing, as if it were an
15 opinion. It is something that is recognized at
16 birth by anatomy, or if there's confusion it's
17 recognized that there's confusion. We do not
18 let a baby boy, that we think is a baby boy,
19 whose testicles are not in the scrotum -- both
20 of them or one or both of them in the
21 scrotum -- we do not let that baby leave the
22 nursery identified as a male or female until we
23 essentially determine whether or not the sex of
24 that baby is male or female.

25 Q. Okay. So did you say that

1 government issued any documents should have the
2 word sex, right?

3 A. It should in that if they're
4 collecting data, which is what government
5 documents are supposed to do, and you are
6 looking at epidemiologist things such as the
7 things that are different from male sex to
8 female sex, and then you're going to need to
9 keep records of those things. And for instance
10 a trans female who comes in -- excuse me. A
11 trans male who comes into the emergency room
12 with abdominal cramping, it's important for the
13 medical diagnosis that it be obvious to
14 everyone that that person is a -- the sex they
15 were born, because their internal anatomy
16 likely in the case of the pregnancy that
17 essentially was a miscarriage, that was because
18 there was no recognition of sex, there was
19 recognition instead of gender. So that's an
20 actual -- and it's rare. I fully admit that
21 made a lot of news because it was splashy, but
22 it was an event which just illustrated the
23 point that you need to know sex differences,
24 not gender differences in terms of medicine and
25 outcomes.

1 Q. Okay.

2 A. The FDA recognizes sex as
3 important, because they make sure that drugs
4 are tested in males and they are tested in
5 females, before they can say they're safe and
6 effective. Because the human body as a male
7 reacts differently than the human female body
8 does. No matter what the gender is perceived
9 to be, the important thing is the sex.

10 Q. So on like identity documents and
11 forms, just to be clear, you think that the sex
12 marked on a birth certificate, the original
13 birth certificate, should be what's on those
14 documents?

15 A. The purpose is to collect data on
16 births to look at population, okay, to
17 establish an anchor of identity, but more
18 important to look at sex. Say percentage of
19 males, percentage of females. Accidents
20 involving -- epidemiologist studies involving
21 males and females. If that's changed, then you
22 skew the data, and you all the sudden lose the
23 biologic proportion of male-to-females, and if
24 you're looking at laws and discrimination, et
25 cetera, et cetera, you're going to lose all the

1 benefit of being able to quantify your
2 population. And this is a government document
3 establishing biologic population.

4 Q. Okay. So just to be clear,
5 though, you think it would be better if
6 documents required a person to list sex that
7 was originally on their birth certificate
8 whenever identifying sex or gender?

9 MR. BLAKE: Objection. Misstates.
10 Relevance.

11 THE WITNESS: I'm saying that in a
12 birth record. Birth record.

13 BY MS. INGELHART:

14 Q. Okay. So not generally identity
15 documents?

16 A. You know, everything else is more
17 of a social construct. So if you on your
18 driver's license say, I have blond hair and
19 blue eyes, and what you really have is brown
20 hair that you have bleached, and you're wearing
21 blue contacts, okay, the reason that the
22 driver's license says blond hair and blue eyes
23 is because if you are recognized in an event
24 where they have to have some kind of identity
25 that's right there and immediate, they have it,

1 and it matches. Okay?

2 Instead of saying you see someone
3 who's blond and blue eyed and on their driver's
4 license it says black hair and black eyes,
5 you're thinking, wait a minute. This doesn't
6 represent what this is, where I need to know
7 right at this very second. This is not a
8 document like that. This is a health record of
9 demographics.

10 Q. Okay. But like in the
11 hypothetical that you introduced with the trans
12 man presenting at a hospital with abdominal
13 pain, you said that it's important that he on a
14 form would list female, right?

15 MR. BLAKE: Objection.

16 THE WITNESS: If there's not a
17 form, at least inform immediately all the
18 medical personnel, I need to tell you something
19 in private. This is all HIPPA compliant. You
20 know, you are my physician. I'm sharing with
21 you the fact that I am actually a female in
22 terms of my sex, but my gender is male.

23 BY MS. INGELHART:

24 Q. Okay.

25 A. I'm concerned, therefore, that I

1 might be pregnant. You know.

2 Q. Yeah. Okay.

3 A. Yeah.

4 (Thereupon, Plaintiffs' Exhibit
5 12, Transgender, a state of mind in search of
6 biology by Dr. Van Meter, PowerPoint photos,
7 was marked for identification purposes.)

8 BY MS. INGELHART:

9 Q. Quickly, I'd like to introduce
10 another exhibit, Exhibit 12. What I have just
11 had placed before you is Plaintiffs' Exhibit
12 12. Do you recognize this document?

13 A. I do.

14 Q. What is it?

15 A. It's a printout of a PowerPoint
16 presentation.

17 Q. Is it a PowerPoint presentation of
18 your own?

19 A. Yes.

20 Q. Do you know when this PowerPoint
21 presentation was used?

22 A. This I believe was what I
23 presented at the meeting of the Southern
24 Pediatric Endocrine Society meeting, in
25 Atlanta.

1 Q. Okay.

2 A. In I think it was 2014.

3 Q. Thank you. Okay. That's helpful.
4 So if you could turn -- unfortunately there's
5 not Bates numbers -- to the second to last
6 piece of paper that is titled, recapturing the
7 language, did you create this Power Point?

8 A. I did.

9 Q. So this third bullet point here
10 says, remove gender and replace with sex on all
11 government and business documents.

12 MR. BLAKE: Objection. That's not
13 what it says.

14 MS. INGELHART: I literally just
15 read it.

16 MR. BLAKE: You literally read it
17 wrong.

18 MS. INGELHART: Remove gender and
19 replace with sex on all government and business
20 documents.

21 MR. BLAKE: You read it again
22 wrong. You're inserting the word all.

23 MS. INGELHART: I'm saying on.

24 MR. BLAKE: You said on all.

25 MS. BONHAM: Why don't we read it

1 one more time for the record?

2 MR. BLAKE: Thank you.

3 BY MS. INGELHART:

4 Q. Okay. Remove gender and replace
5 with sex on government and business documents?

6 A. Yes, I wrote that.

7 Q. Okay. Thank you. This is
8 inconsistent with your prior statement,
9 correct?

10 MR. BLAKE: Objection.

11 THE WITNESS: This is a statement
12 of what if I were in charge and what I thought
13 made sense and what would be honest is what
14 should happen, but that's different than what I
15 previously stated.

16 Okay. Thank you. That's all.

17 MS. INGELHART: For the record, I
18 wasn't trying to intentionally misread.

19 MR. BLAKE: I know you weren't.

20 MS. INGELHART: Okay. Thank you.

21 BY MS. INGELHART:

22 Q. What is gender dysphoria?

23 A. It is a term that was created by
24 the APA committee in creation of DSM-5 to
25 replace the term gender identity disorder to

1 describe the emotional discomfort created by
2 having an incongruent gender and sex.

3 Q. Okay. And it replaced the term
4 gender identity disorder, correct?

5 A. Essentially, in the DSM. Yes, it
6 did.

7 Q. Okay. Is that why in your report
8 you sometimes use gender identity disorder
9 versus the term gender dysphoria?

10 A. It's almost interchangeable with
11 gender incongruence and gender identity
12 disorder and gender dysphoria, because for me
13 they are all essentially the same thing with
14 just different names put to them.

15 Q. Okay. And can you clarify for me
16 what gender incongruence is? I think I
17 understand but...

18 A. It is when there's a mismatch
19 between the gender and the sex.

20 Q. Okay. Thank you. Do you believe
21 it's ever appropriate for a transgender person
22 to undertake gender transition?

23 A. Yeah. I don't think there's any
24 appropriate time or age.

25 Q. Thank you. Is that the view

1 generally accepted within your field?

2 A. Among nonprofessional societies,
3 among colleagues, absolutely.

4 Q. Among all of your colleagues, all
5 pediatric endocrinologists in the U.S.?

6 A. The majority of pediatric
7 endocrinologist colleagues. When I give
8 presentations and take assessment of their
9 response and what they come up to me afterwards
10 and say, it's 75 percent.

11 Q. Okay. Are the people who attend
12 your panels and presentations representative of
13 the entire population of pediatric
14 endocrinologists?

15 MR. BLAKE: Objection.

16 THE WITNESS: I can't state that,
17 but they are representative of the people who
18 come to CME meetings.

19 BY MS. INGELHART:

20 Q. Okay. Thank you. Have you ever
21 taken any steps to facilitate someone's gender
22 transition?

23 A. Yes, I did. In 1994, when I gave
24 that boy some estrogen.

25 Q. Okay. Any other time?

1 A. No.

2 Q. Okay. And on what basis did you
3 do that?

4 A. There was no precedent set in
5 children, and everyone who could advise me said
6 we don't know, but if you're going to do it,
7 this is how you should.

8 Q. Okay. And I'm sorry. Who did you
9 consult with on that?

10 A. Peter Lee, Claude Migeon, Mel
11 Grumbach, Gail Richards in Seattle.

12 Q. And are they all also --

13 A. They were all pediatric
14 endocrinologists, yeah.

15 Q. Okay. Thank you. Thank you so
16 much. Do you agree that individuals with
17 gender dysphoria, if not treated, often suffer
18 clinical significant emotional distress?

19 A. Absolutely.

20 Q. Including depression and suicidal
21 thoughts?

22 A. Yes.

23 Q. Okay. And that it can impair the
24 functioning in their daily lives?

25 A. It does.

1 Q. Thank you.

2 A. It's by definition. That's what
3 gender dysphoria is. It's a description of
4 that impairment.

5 Q. Okay. And again, without proper
6 treatment, do you agree that a significant
7 portion, like 30 to 40 percent, develop
8 suicidal ideation thoughts or attempt suicide?

9 A. It's actually closer to about 20
10 percent, and the study's done at the Williams
11 Institute, where they looked at actual suicide
12 attempts. It is equal to, I believe, autism
13 and just general anxiety and depression.

14 Q. Okay. Do you believe that
15 generally speaking transgender adults can
16 voluntarily change their gender identity?

17 A. I don't know, because I don't
18 treat those. I think at that end of the
19 spectrum it is far more difficult. That would
20 be my experience of listening to the -- to Ken
21 Zucker and knowing what he's written is by the
22 time you get to adulthood, that if you have not
23 desisted, the desistance rate gets narrower and
24 narrower to that point in time. But the point
25 is they need lifelong emotional support.

1 Lifelong psychiatric intervention or
2 psychological intervention. And if you make
3 the assumption that they're done and you've
4 fixed them and let them go, that that's a grave
5 disservice. His point was if they get to
6 adulthood and they choose to transition
7 medically and surgically, they need to be your
8 patients until the end of their life, and if
9 you let them go, they will be in grave danger
10 of harming themselves.

11 Q. Okay. On the in perpetuity,
12 danger of harming one's self if they're not in
13 care, what's the basis for that?

14 A. His personal experience, and then,
15 you know, the Dhejne study talks about just the
16 suicide rate being 20 fold greater.

17 Q. Like the Swedish study?

18 A. Yeah.

19 Q. Okay. And also Zucker's research,
20 as well?

21 A. Right.

22 Q. Okay. Thank you. Do you agree
23 whether a trait is biological and whether a
24 trait can be changed are two different things?

25 MR. BLAKE: Objection. Vague.

1 THE WITNESS: Biological seems to
2 be that there is a genetic programming that,
3 again, I would say that biological means it
4 can't be successfully changed. You can make
5 attempts to do so, but you will not succeed.
6 BY MS. INGELHART:

7 Q. Is it your opinion that there's no
8 genetic component to gender identity?

9 A. That's correct.

10 Q. Okay. Is it your opinion that
11 there's, therefore, no relationship to
12 transgender identity and inheritability?

13 A. Correct.

14 Q. I think we touched on this before,
15 but do you believe that the removal of gender
16 identity disorder from the DSM and its
17 replacement with gender dysphoria was a
18 disservice to patients?

19 MR. BLAKE: Objection. Vague.

20 THE WITNESS: Yes.

21 BY MS. INGELHART:

22 Q. Thank you. Is it your opinion
23 that sex reassignment surgery and treatment for
24 gender dysphoria is a form of mutilation?

25 A. Yes.

1 Q. Okay. For the record, let's turn
2 back to your report. In the initial part of
3 it, Paragraph 24, which is on Page 5 of the
4 initial, so it is the third paper in that file.

5 A. Okay.

6 Q. I think this is what we talked
7 about earlier on the record or off. I'd just
8 like to put it on the record. This statement
9 here, do you hold firm that that's accurate?

10 A. No. I mean those numbers have
11 been modified considerably, depending on how
12 the question is asked in the population. It is
13 now estimated in a study of high school
14 students of Oregon that it's 24 percent of the
15 population that says issues with gender
16 identity.

17 Q. Okay.

18 A. I mean that's the extreme on one
19 side, and somewhere in the middle, the actual
20 standard up until sort of the increase of the
21 adolescence female. I talked about the strange
22 rush in gender incongruence. Two to one
23 female-to-males. Prior to that it was .06. It
24 was 6 out of 100,000 males and 3 out of 100,000
25 females. So that was a respected figure from

1 Europe. Those were the WPATH statistics at the
2 time. It has been modified considerably since
3 then, and I think that's the concern is the
4 repetity of the modification to a hundred fold.
5 You know, going from 200 cases a year to 2,400
6 cases a year in the UK, over a span of 10 years
7 made them sit up and say, what's going on?
8 Let's pause. Let's go and examine exactly what
9 this phenomenon is, because that cannot be
10 explained by social acceptance.

11 Q. Okay. Can I just quickly ask you
12 the terminology here? You used the term
13 biological females and biological males.

14 A. It's redundant.

15 Q. Okay. Thank you.

16 A. Well, actually, no. Biological
17 females, yeah. I mean what that is is the sex
18 is male or female is what that intent was. To
19 use the word biologic sex, as I said, is sort
20 of a redundancy.

21 Q. I see. Okay. Thank you.

22 A. So the biological female refers to
23 female sex. Biological male, male sex.

24 Q. Got it. Not to be confused with
25 female gender?

1 A. Right.

2 Q. Thank you. And you cited to the
3 Endocrine News source for this?

4 A. Yes. And I went back, and I went
5 to see where I found that, and I will have to
6 go back and find out, because I've got a stack
7 in a folder exactly what I used, and somehow
8 inadvertently misstated that that came from
9 that source. And I reread that, because I
10 could look it up, and I said, well, that's an
11 interesting criticism and I want to make sure
12 that I point by point go through. And it's an
13 valid criticism. So I fully say that did not
14 come from that source.

15 Q. Mistakes in footnotes happen.

16 A. I get concerned, because I signed
17 this.

18 Q. Fair. So but generally is the
19 Endocrine News a reputable source?

20 A. No. It's one of the throwaways.

21 Q. Okay. Before I said I wanted to
22 come back to this, and so quickly tie up a lose
23 end. Can we refer back to the Zucker exhibit.
24 What's the number?

25 A. It is 3.

1 Q. Thank you. Can we go back to
2 Exhibit 3 really quickly. Just back to the
3 same place we were before, Page No. 392.
4 Apologies. Can we look at Page 369, the very
5 first page?

6 A. Okay.

7 Q. In the first non-italicized
8 paragraph, this study is indicated to be 590
9 children. Is that how you read that as well?

10 A. Yes. And I may have misstated 560
11 previously, but it's 590.

12 Q. But this is the study you cite to
13 for rate of desistance and --

14 MR. BLAKE: Objection.

15 BY MS. INGELHART:

16 Q. And is that accurate? Is this the
17 study that you cite to for rate of desistance?

18 A. No. DSM is what I also cited to
19 in that.

20 Q. Okay. But this is one of them?

21 A. Yeah. This is one of them.

22 Q. Okay. Thank you. Thank you for
23 the clarification. So this is one of the
24 documents that you cite to for rate of
25 desistance, but this document is just a study

1 of children, correct?

2 A. That's correct.

3 Q. And as we discussed before, rate
4 of desistance among children is higher than
5 rates of desistance amongst adults?

6 A. That's correct.

7 Q. Okay. Okay. Back to your report.
8 Sorry for all the jumping around. We're going
9 to look at the rebuttal portion. So we can
10 flip to the very last page of this stack of
11 papers and to Paragraph 15. Can you refresh
12 your recollection? Do you know what we're
13 talking about?

14 A. Yes. This is the Dhejne study.

15 Q. Okay. And that's the one where
16 you cited for what assertion again?

17 A. That there was nearly 20 times
18 increase of suicide -- completed suicides, not
19 attempts, in patients who had completed the
20 entire gender affirmation process. Social,
21 medical and surgical.

22 Q. Okay. Great. Thank you.

23 (Thereupon, Plaintiffs' Exhibit
24 13, Long-Term Follow-Up of Transsexual Persons
25 Undergoing Sex Reassignment Surgery: Cohort

1 Study in Sweden, was marked for identification
2 purposes.)

3 BY MS. INGELHART:

4 Q. I'm going to introduce another
5 exhibit. This is Plaintiffs' Exhibit 13. If
6 you want to take a look at it. Do you
7 recognize this document?

8 A. I have not combed through it.
9 It's the second or a follow-up study by Cecilia
10 Dhejne. So I'm aware of it, yes.

11 Q. And I apologize, but looking back
12 to the last page here, Paragraph 15 of your
13 rebuttal -- oh, I'm sorry. The other one
14 there. This is where -- I'll wait until you
15 get there.

16 A. Okay.

17 Q. Okay. So it shows on 19-fold
18 increase in completed suicides, and you don't
19 have a footnote here, but is this the study I
20 just introduced? Is that the one that you're
21 referring to?

22 A. No, it's not.

23 Q. It's not?

24 A. No. It's a -- hang on. Hang on.
25 Wait a minute. I can tell you.

1 Q. Yeah. No problem.

2 A. And this is 2000 -- what's the
3 date? No, it is this one.

4 Q. Okay.

5 A. I'm sorry. Yes.

6 Q. Okay. Thank you.

7 A. Yes, yes, yes.

8 Q. Thank you.

9 A. Okay.

10 Q. Okay. So can you explain to me
11 what a 19-fold increase means?

12 A. Well, 19 times the amount of
13 suicides compared to the general populations of
14 Sweden's.

15 Q. Okay. So it's 19 times greater.
16 It wasn't an increase from some other previous
17 measure?

18 A. No.

19 Q. Thank you. Okay. And then in
20 your second sentence here it says -- sorry.
21 I'll let you get there. It says these studies
22 indicate that gender incongruent patients who
23 undergo appropriate treatment and return to
24 identification with their biologic sex are at
25 far less risk for suicide. What do you mean by

1 this study indicates?

2 A. These being --

3 Q. Oh, these. Yes.

4 A. -- a conglomerate of all prior --
5 the studies that are mentioned in the paper.
6 It's not the Dhejne study specifically.

7 Q. Oh, okay. I misunderstood the
8 paragraph. Thank you.

9 A. Okay.

10 Q. Okay. We can set aside your
11 report and then look back to the Dhejne study.
12 Thank you for teaching me how to pronounce the
13 name. We discussed earlier issues with control
14 groups in these studies.

15 A. Right.

16 Q. If you look on the very first
17 page, there's a quick section that's called
18 participants. In the gray box --

19 A. In the gray box. Okay. Right.

20 Q. -- there's participant. So what
21 are the two comparative groups here?

22 A. Random population controls and the
23 trans male-to-females and female-to-males.

24 Q. Okay. And by general population
25 control, what is that specifically?

1 A. That is the population of Sweden,
2 and a sample of the population to look at
3 incidence of suicide.

4 Q. Okay. Thank you. So the
5 non-control group were transgender people,
6 correct?

7 A. That's correct.

8 Q. Who had undergone medical gender
9 affirmation?

10 A. Social, medical and surgical.

11 Q. Thank you. And the control group
12 was generally representative of non-transgender
13 people?

14 A. That's correct.

15 Q. Okay. Can we turn to what in
16 my -- oh, I'm going to try to compare -- to the
17 results section. Whatever that --

18 A. I've got it.

19 Q. Okay. And there's a comment that
20 says, Table 1.

21 A. Yes.

22 Q. That's commenting upon Table 1. I
23 apologize. Could we go off the record really
24 quick?

25 THE COURT REPORTER: Sure.

1 (Thereupon, the deposition briefly
2 went off the record.)

3 BY MS. INGELHART:

4 Q. So on Page 4 of the document that
5 you're looking at in the results section,
6 subsection characteristics prior to sex
7 reassignment, there's a paragraph that starts
8 with the words Table 1. The second sentence
9 says there were no substantial differences
10 between female-to-males and male-to-females
11 regarding measured baseline characteristics.
12 Immigrant status was twice as common among
13 transsexual individuals compared to controls,
14 living in an urban area somewhat more common,
15 and higher education about equally prevalent.
16 Transsexual individuals had been hospitalized
17 for psychiatric morbidity other than gender
18 identity disorder prior to sex reassignment
19 about four times more than the controls.

20 Really it's that last sentence
21 that's operative. Do you understand what that
22 sentence says?

23 A. Yeah. Mm-hmm.

24 Q. Okay. The conclusion -- sorry.
25 There's so much jumping around. In your

1 report, do you cite to the study to say that
2 transition can lead to higher rates of
3 suicidality?

4 A. If you look at a four-fold
5 increase in psychiatric hospitalization versus
6 the 20-fold increase in completed suicides,
7 there is obviously a correlation that there is
8 psychiatric morbidity occurring, okay? We
9 would say, in the trans population. Which is,
10 as far as I'm concerned, indigenous to the
11 disorder or the dysphoria. Okay?

12 Q. Okay.

13 A. So it's not surprising to see that
14 those patients are troubled, but despite that,
15 if it's four times the amount of psychiatric
16 admissions but 20-fold amount of completed
17 suicides, that in my mind, if you look at that,
18 that's a five-fold increase in suicidality, if
19 you will, or completed suicides perhaps. I
20 mean it's an inference that this doesn't state,
21 but it says, we have troubled people to begin
22 with. And what was done for them increased
23 their suicide rate far more than it would be
24 expected. You might have a four-fold increase.
25 If their four-fold's emotionally sick or going

1 in, then that suicide completion would then be
2 maybe four times as much, but it was 20 times
3 as much as the general population. So you've
4 got population that's in the hospital for
5 mental disorder is four times more than the
6 general population and kills themselves 20
7 times more often. That's a multiple factor
8 that indicates that the affirmation was not a
9 successful concept in those patients. The
10 affirmation had a higher risk.

11 Q. So, Doctor, is your inference
12 based on an assumption that there's a direct
13 relationship between rate of hospitalization
14 and rate of suicide?

15 A. No. No.

16 Q. Can you explain then what your
17 basis for saying the transition after these
18 hospitalizations is what caused suicide?

19 A. Well, there was an increase. And
20 so it's just a matter of -- it's an assumption.

21 Q. And what is the increase, though?
22 From what to what?

23 A. Four to twenty.

24 Q. But the four represents the
25 number -- four times as likely represents the

1 number of hospitalizations, correct?

2 A. Right.

3 Q. And 20 represents the number of
4 completed suicides, correct?

5 A. Right.

6 Q. So you're saying an increase from
7 hospitalization to -- you're saying that a
8 change in number value of a hospitalization
9 rate to a rate of completed suicide is
10 something you could describe as an increase?

11 A. It appears to me just on a cursory
12 analysis, and the problem is that there's
13 missing all of the explanations for the
14 hospitalizations and what had prompted them.
15 Was it a suicide attempt? Was it something
16 else that was just an actual depression? What
17 was the grade? You know, why they were
18 hospitalized.

19 So all that's missing. So if you
20 look at it as a comparative, it makes you think
21 these are troubled people, and the affirmation
22 seemed not to help at all and perhaps multiply
23 it.

24 Q. Okay.

25 A. And again I'm just looking at this

1 from the information that I can glean from that
2 statement.

3 Q. Right. Can you look to the
4 section, continuing on, morbidity, that says
5 Table 2 at the top of the paragraph. It's just
6 below where we were before.

7 A. Hang on. Table 2. Okay.

8 Q. The second sentence that begins
9 with the hyphenated word sex-reassigned.

10 A. Yes. Okay.

11 Q. Sex-reassigned transsexual persons
12 of both genders had approximately a three times
13 higher --

14 A. I'm missing -- I'm sorry.

15 Q. It's okay.

16 A. It's under which?

17 Q. It's on Page 4 of the document
18 you're looking at.

19 A. Okay.

20 Q. Under the right-hand column term
21 morbidity.

22 A. I've got that's mortality actually
23 is what it says.

24 Q. You're right. You're right.

25 A. Okay.

1 Q. I'm having some reading trouble
2 today.

3 A. That's okay. That's all right.

4 Q. Sex-reassigned transsexual persons
5 of both genders had approximately a three times
6 higher risk of all-cause mortality than
7 controls, also after adjustment for covariates.

8 A. Okay.

9 Q. Do you understand what that
10 sentence says?

11 A. And I'm not sure I understand it.

12 Q. Okay. Could you tell me what your
13 understanding of it is?

14 A. Actually I mean it sounds to me
15 like there was a three-fold increase of
16 mortality for any reason at all.

17 Q. And you're using the word increase
18 to explain the difference between the
19 controller's measure --

20 A. And control. Right, right.

21 Q. Okay. So can you restate that
22 again? What's your understanding of the
23 sentence?

24 A. It says sex-reassigned transsexual
25 persons of both genders. Meaning that there

1 was not any difference between male-to-female,
2 female-to-male. Had an approximately
3 three-time higher risk of all-cause mortality.
4 Not suicide, but all causes.

5 Q. Okay. Do you think that their
6 transition is the cause of higher rates?

7 A. That would be sheer conjecture.

8 Q. Okay. How is it then not
9 conjecture in the other inference?

10 A. Well, it's a higher statistical
11 difference. Okay? Twenty versus three. Three
12 times is possibly due to other confounding, and
13 this is any mortality, meaning that they could
14 have died of heart disease. They could have
15 died by any other causes. They could have been
16 hit by, you know, a trolley or whatever.

17 Q. Okay.

18 A. Suicide to me means an intended
19 death.

20 Q. I understand.

21 A. Okay.

22 Q. Thank you. We can set aside
23 the -- I already forgot how to say her name.

24 A. Dhejne.

25 Q. Dhejne -- thank you -- study. But

1 one quick question. Is in-patient care at a
2 psychiatric facility always a precursor for a
3 completed suicide?

4 A. No.

5 Q. Okay. Thank you. Do you agree
6 that transgender adults are at greater risk of
7 death by suicide than the general population?

8 A. Yes.

9 Q. What's the impotence of people
10 born with, as you call it, DSDs?

11 A. For the ones that are what we
12 would call ambiguous to the point where
13 identification is not possible by appearance of
14 external anatomy, about 1 in 4,500.

15 Q. Okay. Let's turn to Page 3 of
16 your initial report. So just 3 of that
17 document there. Paragraph 16 here says, for
18 reasons most often occurring as random events,
19 there are malfunctions of the normal
20 differentiation. These aberrations of normal
21 development are responsible for what we
22 classify as disorders of sexual
23 differentiation, or DSD, and they represent a
24 very small fraction of the human population.
25 The incidence of such circumstances occurs 1 in

1 4,500 to 1 in 5,500 births.

2 A. Right.

3 Q. Okay. Does this refer to all
4 DSDs, as the sentence says?

5 MR. BLAKE: Objection.

6 THE WITNESS: It refers to DSDs in
7 the classic sense. You know, ambiguitive
8 genitalia.

9 BY MS. INGELHART:

10 Q. Okay.

11 A. Not the Klinefelter's, not the
12 Turner's syndrome, not to people with
13 hypospadias.

14 Q. Paragraph 14 above here. You want
15 to review it very quick?

16 A. Do you want me to read it out
17 loud?

18 Q. No. You can just read it to
19 yourself.

20 A. Okay.

21 Q. I'm thinking of the wrong one. Is
22 it possible, as we discussed earlier today, for
23 a newborn with XX chromosomes to present
24 phenotypically with a penis and a scrotum at
25 birth?

1 A. Yes.

2 Q. Okay. Would that be a DSD?

3 A. That would be a DSD.

4 Q. Okay. So does that fit into the
5 general definition of DSD, as you said before?
6 Atypical genitalia?

7 A. Well, it's one that will be
8 discovered accidentally, most likely. Like the
9 one case of the XX male that I had, and that is
10 far rarer than the 1 in 5,000. I can't quote
11 the statistic, but it's exceedingly -- I think
12 I'm the only person in my community in Atlanta
13 who's seen an XX male.

14 Q. Okay. Thank you. And let's just
15 turn the page to Paragraph 17, and you can just
16 read it to yourself again.

17 A. Okay.

18 Q. In that paragraph, you referred to
19 the Intersex Society of North America consensus
20 statement and update, right?

21 A. Right.

22 Q. Okay. That group presented the
23 ideas in their consensus statement that you
24 cite to to support your argument, right?

25 A. Yes.

1 Q. Okay. All right. Let's pull up
2 those two.

3 (Thereupon, Plaintiffs' Exhibit
4 14, Consensus statement on management of
5 intersex disorders, and Plaintiffs' Exhibit 15,
6 Global Disorders of Sex Development Update
7 since 2006: Perceptions, Approach and Care,
8 were marked for identification purposes.)

9 BY MS. INGELHART:

10 Q. I'm going to introduce two
11 exhibits at one time. Do you recognize these
12 two documents?

13 A. I do.

14 Q. Are they what you refer to in the
15 third sentence of Paragraph 17 in your report?

16 A. Yeah. Both are Dr. Lee's
17 references, yes.

18 Q. Okay. Thank you. Could you show
19 me in these reports where this consensus
20 statement is attributed to the Intersex Society
21 of North America?

22 A. It's actually a term that was used
23 as a colloquial term. I mean it was an
24 interest group, the Intersex Society. It has a
25 different name and a professional name. The

1 ones that actually ended up publishing. They
2 went through a whole change of nomenclature.
3 Originally, it was called the Intersex Society
4 of North America -- I think, of North America.
5 And then they got together as a consortium and
6 decided on a better name.

7 Q. Okay.

8 A. But it's a colloquialism.

9 Q. Okay. Let's pull up just that
10 last one really quick.

11 A. So just to show you. LWPES is
12 actually the Pediatric Endocrine Society, and
13 ESPE is the European. So that -- sort of if
14 you want to have it as a special interest group
15 called the Intersex Society came together to
16 these two organizations, and then they decided
17 we were going to publish guidelines under an
18 auspice of a new -- of sort of the general term
19 of PES and ESP.

20 Q. And is that on the 2016 update or
21 the original?

22 A. This is the updated. I mean this
23 is the original, and this is the update.

24 Q. Okay. We're going to enter the
25 one-third exhibit for this line of questions.

1 (Thereupon, Plaintiffs' Exhibit
2 16, Dear ISNA Friends and Supporters, was
3 marked for identification purposes.)

4 BY MS. INGELHART:

5 Q. Plaintiffs' Exhibit 16. Do you
6 recognize just the title at the top?

7 A. Yes.

8 Q. Okay. This you can see at the
9 bottom corner of the page where it came from,
10 isna.org?

11 A. Yes.

12 Q. From the Intersex Society of North
13 America's website. The second bullet point on
14 the page, can you read that?

15 A. More cautious approach to surgery.

16 Q. I'm sorry. No.

17 A. In August 2006?

18 Q. Correct.

19 A. Okay. A new standard of care was
20 published in Pediatrics. The consensus
21 statement on management of intersex disorders
22 is an important inroad to resolving this
23 crisis. It incorporates many of the concepts
24 and changes long advocated by ISNA.

25 So that is, again, the

1 organization morphed into something that was a
2 bit more scientifically based, that was
3 broader. It involved the professional
4 societies, because that group, ISNA, was a very
5 small nucleus of people, and they wanted again
6 to get to all pediatric endocrinologists and
7 develop a consensus policy.

8 Q. Okay. But the consensus statement
9 was not actually from --

10 A. No.

11 Q. Okay. How do you know that the
12 consensus statement was conceived in the manner
13 you described?

14 A. By talking to Dr. Lee. He's a
15 personal friend and a mentor.

16 Q. Okay. Thank you. You can set all
17 three of these exhibits aside.

18 Turning back to your report
19 document to Paragraph 19 in the original
20 report, which is on Page No. 4, can you just
21 read it and refresh your recollection to
22 yourself?

23 A. DSD patients are not transgender.
24 They have objective, physical, medically
25 verifiable, physiologic conditions.

1 Transgender people generally do not have
2 intersex conditions -- yeah, generally, you
3 don't have -- or any other verifiable physical
4 anomaly. People who identify feeling like the
5 opposite sex or somewhere in between do not
6 comprise a third sex. They remain biological
7 men or biological women as determined by their
8 chromosomes and sex at birth.

9 Q. Okay. So would you agree that
10 transgender identity and intersex identity are
11 not necessarily mutually exclusive?

12 A. There are obviously cases that --
13 I believe Dr. Gordon said he had had some cases
14 in his experience where there were kids with
15 DSDs, and it depends again on what are you
16 calling a DSD. So if you have a patient who
17 has Klinefelter's, I would not consider that a
18 DSD. All right? If you have a Turner's girl,
19 that's not a DSD. And he did not say which of
20 the DSDs he was talking about.

21 Q. Okay. So they can co-exist with
22 some definitions?

23 A. Yeah. But they're not -- they're
24 not -- it's sort of -- again, the concept of
25 having ambiguous, okay? Or having gonads of

1 one sex and having the physical appearance of
2 the other does not essentially -- that's not an
3 issue of gender identity.

4 Q. Okay. Are you aware of whether
5 there's documentation of transgender people
6 having a different rate of karyotype
7 abnormalities as compared to the general
8 population?

9 A. I'm aware that it's stated, but
10 again it would be a population study. And if
11 you had took all transgenders, and the problem
12 is you can't find all transgenders, and looked
13 at chromosome analysis to see whether or not
14 there were anything. It depends on who
15 presented to you, and also what is -- I guess
16 much like you did in Sweden, take a sample of
17 population and say, .5 percent has a chromosome
18 anomaly.

19 Q. Okay.

20 A. The problem is it's selection
21 bias. We don't know how to find all
22 transgender people. So if you have transgender
23 patients come in that volunteer to have a --
24 and we don't do karyotypes on transgender
25 people. It's not part of the workup. Again,

1 it has no -- the reason to do that is if they
2 had some concern about being an intersex
3 condition, you could verify that.

4 Q. Okay. Okay. Just to the next
5 paragraph on Page 4. In some DSDs there exists
6 more than one set of chromosomes. Can you just
7 clarify for me? What do you mean by more than
8 one set?

9 A. Each cell contains a set of
10 chromosomes. So the gonads can have one set of
11 chromosomes, and the rest of the body can be
12 entirely different. It's called mosaicism.
13 Okay? Skin cells can be -- particularly in
14 kids that have remarkably unusual pigmentation
15 of the skin and stripes and swirls, you can
16 take a biopsy of the one color skin and take a
17 biopsy of another color skin and find genetic
18 differences between the two of those. So that
19 is a mosaicism. It's called a mosaicism. So
20 you can have differences in karyotype from
21 tissue to tissue.

22 Q. So just for my science nerd
23 skills, there's different kinds of ways of
24 having more than one set of chromosomes? It
25 can present in some people like with different

1 skin tones across your body?

2 A. Right. Mosaicism in skin. The
3 most commonly thought of ones is the mosaicism
4 of like a gonadal dysgenesis, which is Turner's
5 syndrome, can have XY, XO karyotype. Both are
6 like 30 percent of the cells are XY. 70
7 percent of the cells are XO. Meaning there's
8 no second X. The patient typically is a girl
9 with Turner syndrome has no functioning gonadal
10 functioning that's testicular, but nonetheless
11 those girls are at risk of having a malignancy
12 develop in their gonad.

13 Q. Okay.

14 A. Their gonads are already damaged
15 by the process of atrophy as part of Turner
16 syndrome, but the standard of care is to go in
17 and take out any residual gonadal tissue or
18 scar to prevent -- if there's any possibility
19 that there was a Y chromosome in those cells,
20 it needs to be eliminated because it has a
21 higher potential for malignancy.

22 Q. So in those instances, the XY
23 cells versus the ones that are XO, so like X
24 missing a sex chromosome, those can be
25 localized, generally?

1 A. They generally are most throughout
2 the body one particular type, but in the gonads
3 you can have -- that's what true hermaphrodisism
4 is is presence of both gonadal functioning,
5 gonadal tissue, that you find on laproscopic
6 exam.

7 Q. I understand. Thank you. Okay.
8 Is it your opinion that biological sex is
9 binary?

10 A. Yes.

11 Q. Does the existence of people with
12 DSDs illustrate that not everyone falls within
13 the two binaries of sex?

14 A. The true so-called, previously
15 called, true hermaphrodites had both cell
16 lines. Okay? So the predominant cell line is
17 the one that ends up taking over, programming
18 the body, creating the hormones, or making the
19 hormones absent to make a body male or a
20 female. So in a case of -- you're either of
21 them. A biologic man -- yeah, a biologic male.
22 You're either male sex or female sex, depending
23 on the predominant cell type and the functional
24 anatomy that goes along with that and the
25 hormones that have been produced. So that's

1 all binary.

2 Q. So inartfully, so correct me, I'm
3 not trying to ask you to assent to my
4 misunderstanding, if one has a chromosomal DSD
5 that would place them somewhere between a
6 typical male or a typical female, you would
7 still designate them on the binary based on
8 like if the majority of their secondary sex
9 characteristics look a certain way?

10 MR. BLAKE: Objection.

11 THE WITNESS: If their body
12 function and response to hormones is one way,
13 you assign it. That's the sex.

14 BY MS. INGELHART:

15 Q. Okay. So folks with DSDs --

16 A. The complete androgen insensitive
17 male is female.

18 Q. Okay.

19 A. Okay. And determined to be.

20 Q. Thank you. That clarifies it for
21 me. Okay. On Paragraph 14, just the page
22 before, you state in the first sentence, a
23 fetus is determined to be either a male, XY, or
24 female, XX. That's correct. Yes?

25 A. That's correct.

1 Q. Are fetus chromosomes karyotyped
2 generally?

3 A. No.

4 Q. Okay. Do you agree that without
5 photographic or very detailed writing at the
6 time of birth, describing the genitals, you
7 cannot be certain that a person with an M on a
8 birth certificate had typical genitals compared
9 to most people marked with an M at birth?

10 MR. BLAKE: Objection.

11 THE WITNESS: I'm not sure I
12 understand your question.

13 BY MS. INGELHART:

14 Q. Sure. Do you agree that without
15 like a photo of a baby's genitals or somebody
16 really writing up what those characteristics
17 look like, that we can't be certain that
18 somebody with an M on a birth certificate had
19 typical genitals of an average male?

20 MR. BLAKE: Objection. Vague.

21 THE WITNESS: So the exam of a
22 newborn, okay, the first thing is a quick
23 impression. The second thing is before the
24 birth certificate is ever completed is the
25 complete head to toe exam by a physician or a

1 second level provider who pays very detailed
2 attention to the genitalia. So if there is
3 virilization of the female, it's noted.

4 If there is an absence of
5 testicles in the scrotum but everything else
6 looks fine, again, that is so important. It's
7 not just looking. It's actually hands on. You
8 pull the testicles down in the scrotum, and at
9 that point of time in a term baby the testicles
10 are easily found in the scrotum. They're not
11 retractile, because the baby has testosterone
12 levels very typical of an early pubertal male
13 at that point in time, at the end of the third
14 trimester.

15 If you just look across the room
16 and you don't touch the scrotum and you don't
17 find each testicle down, that's an incomplete
18 exam. That would be called a cursory exam, and
19 there should be nothing cursory about an exam
20 of a newborn. It needs to be head to toe,
21 totally detailed. Heart, lungs, fingers, toes,
22 scalp hair patterns, presence of cataracts,
23 missing digits, dimples, sinus tracks,
24 everything. Everything has to be looked at.

25 So if it's cursory, it's an

1 inappropriate exam, and it's inefficient and
2 inappropriate. So determining that has a very
3 significant -- although it seems mundane.
4 Like, yeah, I can tell from here to there that
5 that's a baby boy across the room in the
6 bassinet, you don't know that until you've
7 actually examined the patient completely.

8 BY MS. INGELHART:

9 Q. So two questions. Is that a
10 standard of care?

11 A. Yes, it is.

12 Q. Okay. And where did you learn
13 that information?

14 A. From the first days of medical
15 school, and then really re-enforced in
16 pediatric rotations in medical school and then
17 in pediatric residency and certainly in
18 fellowship.

19 Q. Does it ever happen that intersex
20 babies who have atypical genitals are still
21 marked with an M or an F, just based on an
22 exam?

23 MR. BLAKE: Objection.

24 THE WITNESS: Yes. That has
25 happened, and it's a tragedy when it comes down

1 the pike as finally discovered to be
2 inappropriate, and it happens.

3 BY MS. INGELHART:

4 Q. Without a karyotype, we can't be
5 certain what a person's sex chromosomes are,
6 right?

7 MR. BLAKE: Objection.

8 THE WITNESS: Yes. By definition.

9 BY MS. INGELHART:

10 Q. But in your report at Paragraphs
11 31 -- initial report, Page 5, Paragraphs 31 to
12 34 on Page 6, you conclude for each of the four
13 plaintiffs that you know what their sex
14 chromosomes are, correct?

15 A. It's a conclusion based on
16 information provided, without a physical exam.
17 So I mean, totally inclusive, I've never
18 examined any of the patients. So I cannot
19 state emphatically. It is just the evidence
20 presented, done by other people, who I assume
21 did an exceptionally appropriate job, but
22 that's what was reported to me. And by
23 information in their statements.

24 Q. Okay. But it is an assumption?

25 A. It's an assumption.

1 MR. BLAKE: And I'll say we're
2 willing to withdraw those conclusions if you
3 guys will submit for karyotypes. I mean is
4 that what we're doing with these questions? If
5 they want to submit for a karyotype, we'll
6 withdraw the conclusions.

7 MS. INGELHART: No, thank you.

8 MR. BLAKE: Okay.

9 BY MS. INGELHART:

10 Q. What's the appropriate gender
11 pronoun for a transgender person who's
12 transitioned?

13 A. I am told in order to be sensitive
14 and not offensive that you chose the pronoun
15 that they ask you. So you ask a patient what
16 they wish to be called, and that's what you
17 call them.

18 Q. And in general is that your course
19 of practice?

20 A. That's my course of a practice,
21 and, you know, I sometimes stumble
22 accidentally, and I will apologize in that case
23 if I use a wrong name or a wrong pronoun.

24 Q. Thank you. Okay. Do you think
25 that civil rights should be based only on

1 immutable biology?

2 MR. BLAKE: Objection. Relevance.

3 Answer, if you know.

4 THE WITNESS: I don't have an
5 opinion, but I'm -- I can say I have experience
6 to say.

7 (Thereupon, Plaintiffs' Exhibit
8 17, Breitbart, Doctors' Political Group Places
9 Gender Ideology Above Biology, was marked for
10 identification purposes.)

11 BY MS. INGELHART:

12 Q. What's being placed before you is
13 Plaintiffs' Exhibit 17.

14 A. Mm-hmm.

15 Q. Can you turn to the last
16 paragraph? It starts with a quote, it is high
17 time?

18 A. What page?

19 Q. Oh, I'm sorry. It should be the
20 third page of the, you know, the double-sided.
21 I think we have all of the comment sections in
22 there.

23 A. It's high time that governmental
24 agencies at the national and local levels
25 return to valid science, which reveals that

1 there are two biologic sexes, and the only two,
2 male and female. Gender identity is a social
3 construct, not a biologic one, and
4 gender-specific rights have no place in
5 regulation of law.

6 Q. So would you like to answer their
7 question again?

8 A. Surely. I mean that's my specific
9 opinion, that gender specific rights are not
10 biologically based. And to me race and sex are
11 biologic, and that's a fact. And therefore,
12 rights are appropriate for the individuals, and
13 discrimination against the individuals based on
14 a biologic precept -- the patient has no
15 control, and there is no changing that. You
16 don't change your race by wishing. You don't
17 change your sex by wishing. Okay? So gender,
18 since it's a wish, is exactly that, and
19 therefore I can't imagine a civil right or a
20 law that would protect my wishes.

21 Q. Is that a medical opinion?

22 A. It's a personal opinion.

23 Q. Do your professional opinions and
24 decisions generally concur with those of the
25 American College of Pediatricians?

1 A. Generally.

2 Q. Okay. I think we can set aside
3 this Breitbart exhibit.

4 (Thereupon, Plaintiffs' Exhibit
5 18, Gender Identity Issues in Children and
6 Adolescents, was marked for identification
7 purposes.)

8 BY MS. INGELHART:

9 Q. We just presented you with
10 Plaintiffs' Exhibit No. 18. Do you recognize
11 this document?

12 A. This was a document produced from
13 a presentation that I gave at the American
14 College of Pediatricians' meeting. A CME
15 meeting. I believe it was in Houston.

16 Q. Okay.

17 A. So it was basically a distillation
18 from my PowerPoint presentation.

19 Q. The one that we looked at before?

20 A. No. A different one.

21 Q. Oh, I'm sorry.

22 A. Yeah. A different one.

23 Q. Okay. Thank you. Okay. Can we
24 turn to Page 3, under the sub heading, the role
25 of psychotherapy? Let me know when you're

1 there.

2 A. I'm there.

3 Q. Okay. Could you read the third
4 sentence right after the Page No. 238?

5 A. Yes. There is clearly an
6 opportunity to recruit the gender change option
7 in the pre-adolescent if the therapist has such
8 an agenda.

9 Q. Can you explain what you mean
10 there?

11 A. Yes. People who advertise that
12 their practice is gender dysphoria specialty or
13 gender identity specialty basically recruit
14 patients, and the one in Atlanta that claimed
15 her 37 years experience, I asked her
16 specifically, how many of your patients that
17 came to you of any age at any point in time
18 that walked in your door returned and desisted?
19 And it was like a deer in a headlight. She had
20 never done that. Not a single patient.

21 Now, that flies in the face of all
22 published studies, and she is labeled as a
23 transgender specialist psychologist in Atlanta.
24 Okay? So that was the reference to that kind
25 of behavior in the therapist. The Queer Med

1 office that basically refers to specific
2 psychologists that when you walk in the door
3 you are as if somebody sent on the transgender
4 pathway.

5 Emory University. One of the
6 patients that the mother came to me for a
7 second opinion. There was never any discussion
8 about psychological evaluation of the patient,
9 of the family, of the background, but puberty
10 blockers were offered because this patient was
11 starting to develop breasts or they thought was
12 starting to develop breasts and had some pubic
13 hair. And so that patient was scheduled to be
14 put on puberty blockers, but first the person
15 who was running the clinic, the physician in
16 charge, ordered some lab work just to verify
17 that this was puberty. As it turned out, it
18 wasn't puberty.

19 When I saw this patient, she was
20 not pubertal at all. It was things that looked
21 like puberty. She had chest fat, but no breast
22 tissue, no estrogen effect anywhere. Her pubic
23 hair growth was what we call premature
24 adrenarche. It's not puberty, but it's the
25 adrenal gland component of future puberty that

1 starts body odor, acne and hair growth, and
2 that's what she had. She did not have puberty.
3 The lab test came back showing she wasn't in
4 puberty, and only for that reason did this
5 physician not start her on puberty blockers.

6 Q. Okay.

7 A. The mother, I questioned her. I
8 said, well, who from the staff? She said, I've
9 never met any of the staff. This is her father
10 who took her over to this clinic. The father
11 and the father's girlfriend took her to this,
12 and that was at the recommendation of the
13 counselor that they see. I've never been
14 interviewed by the counselor. I've never had
15 anything to do with that. I just heard she was
16 going over to get puberty blockers. This is
17 the biologic mother of the child, and this
18 biologic mother had custody of this child
19 because of the abuse, physical abuse, by the
20 father and emotional abuse by the father. The
21 mother acquiesced and let the girl live with
22 her father and gave permission to the court so
23 that she could live there, because her older
24 sister insisted, and her older sister wanted to
25 live with Dad, because Dad gave the girl

1 anything she wanted. Phone privileges, access
2 to the internet 24/7, and Mom would not let
3 that happen.

4 So Mom said, fine. You know, I'm
5 sick and tired of fighting. I'll let this
6 happen. You know, I'm going to be watching
7 what's going on. And when she found out that
8 the child had been sent to Emory and was going
9 to be transitioned, she came to me and said,
10 what's going on here? Can you help me?

11 So this is a case typical of
12 transgender clinics, unfortunately, where these
13 kids essentially walk in the door, and there
14 are no questions asked. There is no evaluation
15 psychologically. They are immediately transed,
16 and that's called the transgender experts, and
17 to me it's an abomination. And it doesn't go
18 along with the Endocrine Society guidelines,
19 which say you need to be evaluated thoroughly
20 by a competent mental health care professional.

21 Q. Okay.

22 A. All right.

23 Q. And you just stated that this
24 happens often?

25 A. Yes.

1 Q. On what basis do you know the
2 frequency of it?

3 A. So there are endocrinologists and
4 pediatricians who have made their way
5 physically into transgender clinics to observe.
6 The one case in Colorado, and the woman
7 specifically said, I'm not going to tell you
8 where it happened, because it's client
9 privilege and stuff, but she said I walked in
10 and I was a guest and I was held peripherally
11 so I was not allowed to hear deliberation of
12 the faculty at all, but the patient came in and
13 essentially the staff told her that everyone
14 that comes in is transitioned. Everyone that
15 comes in is transitioned.

16 The woman who runs the clinic in
17 Cincinnati admitted everyone that comes in is
18 transitioned. So if you ask a question of
19 three of four different transgender clinics and
20 you always get the same answer, I'm
21 extrapolating that that's more common than it
22 is uncommon.

23 Q. Okay. Thank you. Are the gender
24 transition experts, people who hold themselves
25 out as experts, are they specialists?

1 A. Not always. The clinic in
2 Cincinnati is run by a nurse practitioner.

3 Q. Okay.

4 A. The clinic in San Francisco is run
5 by a clinical psychologist.

6 Q. Okay.

7 A. Emory's clinic is run by a
8 pediatric endocrinologist. So I don't think
9 that's a requirement, and from the
10 publications, again, in the throwaway things,
11 where there are these repeated statements and
12 articles about affirmation being the way to go
13 and what you do and these are the guidelines,
14 they are often written by directors of clinics
15 who are not physicians and not medical
16 subspecialists.

17 Q. Okay. Do you know whether most
18 folks who arrive at one of these gender clinics
19 or to the offices of one of these experts like
20 the woman in Atlanta, if they're referred to
21 those offices?

22 A. They are often referred by mental
23 health practitioners.

24 Q. Okay.

25 A. Or more commonly now the kids come

1 from the internet and say, this is what I want.
2 Or the schools will refer them.

3 Q. Okay.

4 A. A lot of the information comes
5 from the schools.

6 Q. Okay. So mental health treatment
7 that you've identified today as a part of the
8 wait and watch sort of treatment path, that
9 involves counseling, correct?

10 A. That's correct.

11 Q. Okay. Do you know whether gender
12 affirmation type treatment that these
13 colleagues of the gender clinics provide
14 involve mental health treatment?

15 A. I'm told that it does, but it's
16 aimed at the family for learning how to accept
17 or not be negative in any way.

18 Q. You don't know whether it is aimed
19 at the individual patient?

20 A. It is specifically stated not
21 aimed, in the Seattle clinic. It's not aimed
22 at the patient specifically. It's aimed at the
23 family.

24 Q. Okay. So I'm still looking at
25 this reduction of your PowerPoint to the ACP

1 here. I want to turn the page to Page 4 and
2 look at the top of it.

3 A. Okay.

4 Q. You know what. It might be
5 helpful actually, if you start reading the
6 paragraph at the bottom of Page 3. I don't
7 want us to read out of context. Could you
8 start the sentence that starts --

9 A. All right. The transgender
10 community has a worldwide organization, WPATH,
11 which promulgates the idea that humans are born
12 transgender and that these transgendered people
13 have civil rights as a class of individuals.
14 WPATH holds conferences internationally,
15 nationally and regionally to promote its
16 ideology. WPATH maintains a bibliography for
17 use by its members to help provide testimony
18 for legal battles. It developed standards of
19 care for transgender medical treatment. It
20 provides expert opinion for the mainstream
21 medical societies which are so focused on
22 political correctness that they accept these
23 opinions without any credible scientific
24 scrutiny. These networking efforts then
25 encourage the professional societies to write

1 policy guidelines which are sent to educators,
2 government agencies and to physicians. Their
3 dogma is that gender must be taught to children
4 as a spectrum, not as male or female and that
5 this education should begin in kindergarten, if
6 not pre-school. They promote early
7 cross-dressing, and are the major behind the
8 scenes pushers of anti-bullying campaigns.
9 People who question the validity of innate
10 transgenderism are labeled as racists, and the
11 transgendered are coddled as victims.

12 Q. Okay. I just have a few questions
13 about a term definition.

14 A. Sure.

15 Q. What do you mean by the word
16 dogma?

17 A. A fact that's just a statement
18 that cannot be denied. It is a core value that
19 no one can question.

20 Q. Okay. Is the dogma necessarily
21 not credible? I'm just trying to understand
22 the connotation.

23 A. A dogma can be credible.

24 Q. Okay.

25 A. Okay. But dogma is often used in

1 terms of religion. Okay?

2 Q. Okay.

3 A. So this is a profound belief which
4 is not to be questioned.

5 Q. Okay.

6 A. I mean you can answer it but
7 sorry, Charlie, it's not going to change.

8 Q. Okay. And then the anti-bullying
9 campaigns referenced there. To what were you
10 referring?

11 A. Bullying has been going on
12 forever. It has only recently become an issue
13 when it had to do with same sex attracted kids
14 and transgender kids. Okay? No one cared a
15 whip or had any guidelines or protected bullied
16 kids when it was just a mean bully picking on a
17 kid who was, you know, victimized in fourth
18 grade because he had a pencil bag that was the
19 wrong color or jealousy or whatever it was.

20 So I look at bullying as a
21 two-part process. We have a bullier who is
22 troubled, a very troubled person, and that
23 bully needs a lot of attention, not
24 condemnation. But understanding, what happened
25 to you that makes you have to put somebody else

1 down physically or emotionally to bring
2 yourself up?

3 So if we just go for the victim
4 and hold that victim and coddle them and say,
5 I'm sorry, the world is a terrible place,
6 you're going to be okay, and leave it at that,
7 we're not going to change the world at all. So
8 that's been there since time and memorial. It
9 only became a real hot button issue when it
10 involved the gay and transgender community. It
11 should have been a hot button issue all along.
12 I mean it needed to be understood, and it was
13 just swept under the carpet until it had to do
14 with people who were of a class of, I mean, and
15 honest to goodness, victims. There is no
16 question. And so it's all about compassion,
17 but it all of the sudden became important, when
18 it should have been important forever.

19 And the context here is that
20 anti-bullying got to where it is today because
21 of the focus on gay bullying and transgender
22 bullying. It should have been there all the
23 time.

24 Q. So your sentence here, the
25 sentiment is meant to say that bullying is an

1 important topic; is that correct?

2 A. Yes.

3 Q. Is there any problem with the
4 anti-bullying campaigns that have focused on
5 LGBTQ kids?

6 A. No. None whatsoever.

7 Q. Okay. Okay. All right. And then
8 the last word is coddled as victims. Can you
9 just explain to me what the connotation of the
10 word coddled means here?

11 A. It basically takes somebody who is
12 not a victim but is an emotionally troubled
13 person, and it basically says you're not
14 emotionally troubled. You know, we have a
15 solution for you with affirmation that will
16 completely eliminate all your troubles. And so
17 we're going to protect you from essentially
18 going and getting the cobwebs and the dark
19 places out of your life, and we're going to
20 just paint over those with a really shiny coat,
21 and I'm sure it's going to be fine some day. I
22 mean it's just going to be really fine.

23 And what we know is that -- and we
24 talked about the people who've come back all
25 the way from 30 or 40 years living as trans

1 people, who come back from that and are now
2 finally finding a voice as a group of
3 individuals and saying, oh my God. These are
4 adults. These are people who did things not
5 because they were talked into it as a child.
6 These are people who made the decision, who
7 sought the treatment, who sought the medicine,
8 who volunteered for the surgeries, and they are
9 coming back now and saying, this is tragic.
10 This is never the answer. It's really --
11 please, don't do this. Please, don't do this.
12 Come talk to me. I will tell you how I felt,
13 all the things that I went through that I can
14 teach you that I thought was a solution to the
15 problem, and I found out that it is not. It
16 never was a solution, and what I really needed
17 to do was to find the therapy that I needed
18 right at the very beginning.

19 And these people who are now
20 writing actually late in their life did that,
21 and they are crusaders standing up and saying,
22 please. It's not that we're going to go and
23 sue the physicians that did this to us, because
24 we asked them to. I mean, fully cognizantly
25 asked them to do this. We chose this for

1 ourselves, but it's wrong for you, and I don't
2 want you to go that direction.

3 Q. Are those like case study
4 publications?

5 A. No. These are actually people
6 who -- I mean they're individuals who have been
7 through that, who then come back and act as --
8 then they're using the internet and blogging to
9 say, hey, you know, you have a place to speak
10 here. You don't have to hide. These people
11 hid for the longest time out of shame. I mean
12 their whole recommendation is that the majority
13 of transgender adults who are happy at their
14 point in life are going to be very strong at
15 promoting this as an answer, but the vast
16 majority that are unhappy have just been dead
17 quiet for fear that -- you know, they said, I'm
18 a fool. I am the fool. I'm going to stand up
19 in front of everybody and tell them that I'm a
20 fool. You know, I'm just going to be quiet and
21 live my life. I'm not going to answer surveys.
22 I'm not going to be a statistic. I'm going to
23 disappear. I probably am going to die early,
24 and so be it, and I'm a lonely, terrible
25 person. And they have pulled these people out

1 of the woodwork to discuss things with them on
2 blogs.

3 And so Walt Heyer is one of them,
4 who has a blog, and I can't remember the name
5 of his website, but I think the word is regret
6 is in there. But you can -- Heyer is his last
7 name. He's a beautiful human being who openly
8 discussed all of the things he went through.
9 Hasci Horvath, who's an epidemiologist at UC
10 San Francisco is another very articulate,
11 incredibly intelligent man, who knows. He sort
12 of unraveled the myth of the suicide rates, and
13 he's written letters in blogs and published,
14 and that's another individual. And they're
15 starting to support each other in network and
16 say, please, don't do this to yourself.

17 Q. Okay. Thank you.

18 A. I'll spell that later.

19 Q. Yeah. I'm actually curious. If
20 you don't mind spelling it now?

21 A. Sure. It's H-a-s-c-i
22 H-o-r-v-a-t-h or -- yeah. Horvath, I think.

23 Q. Thank you.

24 A. Yeah.

25 Q. Okay. A few more exhibits here.

1 We can put this to the side.

2 (Thereupon, Plaintiffs' Exhibit
3 19, Breitbart, Judge Finds Father Guilty of
4 Family Violence For Not Using Transgender
5 Teen's Preferred Pronouns, was marked for
6 identification purposes.)

7 BY MS. INGELHART:

8 Q. Do you recognize this exhibit
9 that's been put before you? It's Plaintiffs'
10 Exhibit 19.

11 A. This one says, judge finds father
12 guilty of family violence for not -- yes. Yes,
13 I am. Yes.

14 Q. Okay. Thank you.

15 A. This I believe is Vancouver case.

16 Q. Okay. Thank you for that.

17 A. I only knew initials. They never
18 gave us names.

19 Q. Okay. Yeah. So this is
20 Plaintiffs' Exhibit No. 19. It's a Breitbart
21 article. 5.7 million in tax payer funds for --
22 oh. Am I looking at the wrong one?

23 A. It's the wrong one.

24 Q. Okay. We can look at that one.
25 Sorry.

1 A. Okay.

2 Q. Okay. My apologies. They all
3 look the same. Okay. So Plaintiffs' Exhibit
4 No. 19. We'll do that one. Breitbart. Judge
5 finds a father guilty of family violence for
6 not using transgender teen's preferred
7 pronouns. Can we turn to what will be Page 4
8 of this printout? Can you read into the record
9 that quote from you on this page?

10 A. There's nothing normal about the
11 environment where these children are brought
12 up. There are emotional traumas left and
13 right. It is so obvious that what we're doing
14 is painting over the trauma.

15 Q. Okay.

16 A. This is the recruitment of a cult.
17 It is so scary, and I am so overwhelmingly
18 worried about the welfare of this population of
19 people 30 years out.

20 Q. Can you explain to me what you
21 mean by cult?

22 A. It's a term that again is about
23 the recruitment online. This is a -- it is
24 almost a religious faith, if you will, without
25 scientific basis. It draws people in with a

1 promise of something that is not based on
2 reality. It separates kids from families. So
3 it's an indoctrination, if you will, and that's
4 what I mean by cult.

5 Q. So you think the online presence
6 or the transgender community is a cult?

7 A. It's an indoctrinating society.
8 Cult. Yeah. That's what I mean.

9 Q. Thank you. All right. You can
10 put that aside.

11 (Thereupon, Plaintiffs' Exhibit
12 20, Breitbart, \$5.7 Million In TaxPayer Funds
13 For Study To Justify Sterilizing Children Who
14 Are Gender Confused, was marked for
15 identification purposes.)

16 BY MS. INGELHART:

17 Q. We'll introduce Plaintiffs'
18 Exhibit 20. Do you recognize this document?

19 A. Yes.

20 Q. Can you read the title and the
21 publication name?

22 A. It's Breitbart, I assume News.
23 I'm not sure. It just says Breitbart at the
24 top. \$5.7 Million in taxpayer funds for study
25 to justify sterilizing children who are gender

1 confused.

2 Q. Great. Thank you. On the what I
3 think is the third page of your document
4 there's a paragraph that starts with a
5 quotation mark, since this has all started. Do
6 you see that?

7 A. Yes.

8 Q. Could you read that paragraph?

9 A. Since this has all started, every
10 single transgender patient who has come to me
11 has come from a totally dysfunctional family.
12 There's nothing normal about the environment
13 where these children are brought up. There are
14 emotional traumas left and right. It is
15 obvious that what we're doing is painting over
16 the trauma.

17 Q. What do you mean, since this has
18 all started? Could you explain?

19 A. Since the movement of transgender,
20 the expansion of the number of patients and
21 their presenting of symptoms.

22 Q. And is that related to the
23 transgender civil rights movement?

24 A. It's just related to the advocacy
25 movement. I don't look at it really as a civil

1 rights movement.

2 Q. Okay. Okay. And once again, all
3 of these people come from dysfunctional
4 families. All of your 14 or 15 active patients
5 now, each and every one comes from --

6 A. A dysfunctional family, yes.

7 Q. Okay. Based on that criteria --

8 A. Yes.

9 Q. -- that we discussed before?
10 Okay. We can put this aside. Thank you.

11 (Thereupon, Plaintiffs' Exhibit
12 21, Emergency Petition For Writ of Mandamus,
13 was marked for identification purposes.)

14 BY MS. INGELHART:

15 Q. Okay. One more exhibit. What's
16 been presented before you is Plaintiffs'
17 Exhibit No. 21. Do you recognize this
18 document?

19 A. Let me go through it.

20 Q. Sure.

21 A. It's been a while.

22 Q. Take your time.

23 A. This is an Amicus brief.

24 Q. In what matter?

25 A. It related to Obergefell, I think.

1 The decision. Let's see here. Let me go
2 through it.

3 Q. Sure. Take your time.

4 A. This is about -- well, hang on.
5 We've done a number of amicus briefs. So this
6 is in regard to same sex marriage.

7 Q. Okay. Thank you. Is this in the
8 Supreme Court of the State of Alabama?

9 A. Yes, it is.

10 Q. Okay. And the date on this should
11 be pretty -- yeah. It's in the top left corner
12 of the first page. What's the date on this?

13 A. 11/06/2015 is what I've got.

14 Q. Okay. Do you recall what you were
15 asking the Alabama Supreme Court to do when you
16 signed onto this amicus effort?

17 MR. BLAKE: I'm just going to
18 object to this document and --

19 THE WITNESS: Okay. (A) I did
20 not --

21 MR. BLAKE: Let me finish my
22 objection.

23 THE WITNESS: Okay. Sorry.
24 Sorry.

25 MR. BLAKE: I'm just going to

1 object to this document and the line of
2 questioning on the same grounds that I objected
3 to the previous documents.

4 MS. INGELHART: And we granted you
5 the standing objection. So we can just --

6 MR. BLAKE: I didn't ask for a
7 standing objection, but thank you. On the same
8 grounds as before, involving relevancy of
9 questions and documents related to same sex
10 marriage in this case.

11 Go ahead. You can answer.

12 THE WITNESS: Okay. So I did not
13 write this document, but it's a document where
14 the college chose to support the proven benefit
15 of a biological mother and father family to
16 raise a child. And so to support that and to
17 say that disrupting that was not in the best
18 interest of children.

19 BY MS. INGELHART:

20 Q. Okay. Can you please turn to Page
21 37 of the actual brief. The page numbering of
22 the brief changes many times. I think you're
23 getting close to it, based on what I can see
24 across the table. There's -- at the top of
25 Page 37 there's a sub heading that says, this

1 Court should consider, et cetera, et cetera.

2 Do you see that?

3 A. Yes, I do.

4 Q. Okay. Under that sub heading
5 below that, foundations of American
6 jurisprudence, can you read the first clause of
7 the first sentence?

8 A. It is not beyond the scope of this
9 Court to acknowledge the moral foundation of
10 God's law when considering the institution of
11 marriage: But from the beginning of creation,
12 God made them male and female. Therefore, a
13 man shall leave his father and mother and hold
14 fast to his wife, and the two shall become one
15 flesh.

16 Q. Thank you. Do you agree with
17 those statements?

18 MR. BLAKE: Objection.

19 THE WITNESS: As a person of
20 religious faith, it's part of my religious
21 beliefs.

22 BY MS. INGELHART:

23 Q. Okay. Do you have any religious
24 beliefs related to -- other religious beliefs
25 related to LGBT people?

1 A. Yes. Love thy neighbor as
2 thyself.

3 Q. Okay. Do you have any religious
4 beliefs about people transitioning their
5 gender?

6 A. Love thy neighbor, love thy child,
7 show compassion. It's the religious basis of
8 what my faith tells me to do.

9 Q. Okay. Have you been asked to
10 render an expert opinion regarding how the Ohio
11 Department of Health's position -- not to make
12 corrections or changes to the sex field on a
13 transgender person's Ohio birth certificate
14 affects transgender people?

15 A. Render an opinion? No, I have
16 not.

17 Q. Okay. Did you render another
18 opinion in this matter?

19 A. That sex is biologic and gender is
20 a state of mind.

21 Q. Okay. Do you know what the
22 underlying dispute in this case is?

23 A. That the plaintiffs are indicating
24 that their lives are affected adversely by
25 having a birth certificate which is not -- it

1 says that their sex is not identical to their
2 gender.

3 Q. Okay. Okay. So that you were not
4 asked to render an opinion about how the Ohio
5 Department of Health's position, not to make
6 those changes, could affect transgender people?
7 That's not what you were asked to do?

8 A. I recall to say what is the
9 difference between gender and sex and the basis
10 of those, and that's basically what I was
11 asked.

12 Q. Okay. And all of your expert
13 opinions are reflected in this report and this
14 rebuttal?

15 A. Yes. With the corrections of the
16 things that I misspoke.

17 Q. Thank you. Okay.

18 MS. INGELHART: Can we take a
19 quick break? I have just one module left. I
20 just want to make sure I didn't miss anything
21 with my co-counsel.

22 MR. BLAKE: Sure.

23 MS. INGELHART: Can we go off the
24 record?

25 THE COURT REPORTER: Yes.

1 (Thereupon, a break was taken.)

2 BY MS. INGELHART:

3 Q. Okay. Have you ever asked or
4 applied to be a member of WPATH?

5 A. No, I have not.

6 Q. Can we look back at your CV in
7 your report? I just want to clarify my
8 understanding of your presentations.

9 A. Okay. Here's my report.

10 Q. Sure. Page 4 of your CV, when you
11 get to that, let me know.

12 A. Mm-hmm.

13 Q. Okay. Under abstracts and
14 letters. When we were researching these, some
15 of them had like locations and dates. Are some
16 of these presentations?

17 A. They were presentations. Abstract
18 presentations.

19 Q. Got it.

20 A. Yeah. So they were not then
21 included in a -- they were in a volume that was
22 germane to the meeting but not published.

23 Q. I understand. Is that the case
24 for all of them?

25 A. No.

1 Q. Okay.

2 A. Well, the third one was also a
3 companion. It was done as a presentation,
4 which was not published. The rest are Rogol
5 and Kurt Midyett and George Bright. Those were
6 all part of presentations at meetings, and some
7 of them were published.

8 Q. Okay. Thank you. And then on
9 Page 5, the one that says Endocrine Society
10 meeting in Orlando, Florida, there's a number
11 of it looks like co-presenters with you on that
12 matter.

13 A. Which?

14 Q. It starts with Wayne V. Moore,
15 Patricia Y.

16 A. Yes, yes, yes.

17 Q. Okay. It looks like there were a
18 number of co-presenters with you on that.

19 A. Mm-hmm.

20 Q. And the title of your presentation
21 was Safety and Efficacy of Somavariatan, et
22 cetera, et cetera. I was able I think to find
23 a study by that title with a number of your
24 co-presenters as authors. Did you present on
25 like a study of theirs with them?

1 A. I did not present. There were a
2 number of papers that were from this group. I
3 was part of a clinical study, and we had a
4 large number of patients, and therefore I was
5 asked to be -- it was a hierarchy of who gets
6 to have their name on the paper, if they did a
7 larger proportion of the work. So the
8 abstracts are written. They are passed by us
9 to review all the statistics. Of course, we're
10 all part of that. But I did not actually --
11 you know, I might have corrected a grammatical
12 error or something in there. But they're asked
13 for us to review.

14 And I'm a very poor editor. So I
15 tended to say, as long as the facts looked
16 good, I'm not going to, you know, mess with it
17 anyway. So...

18 Q. Okay. And now we are truly done
19 with exhibits.

20 A. Okay.

21 Q. Maybe not. We are. Okay.

22 We talked earlier about a
23 conference I think you did in maybe Dallas or
24 Houston. Houston. Have you done other
25 conferences and presentations on transgender

1 related matters?

2 A. I have.

3 Q. How many-ish?

4 A. I was invited by the Australian
5 Family Association last August to come and
6 present essentially the same concept of a talk,
7 historical background in comparisons of modes
8 of therapy, and there was the same talk given
9 in Sidney and Cabramurra and Melbourne and
10 Brisbane and Perth.

11 Q. Okay.

12 A. So that was last summer. I gave a
13 presentation at the third meeting of the
14 International Federation of Therapeutic
15 Counseling Choice, in Budapest.

16 I gave a talk in March at the
17 combined meeting that -- it was called the
18 Matthew Bulfin, B-u-l-f-i-n, Conference, and
19 that was held in -- oh, it's foggy, but it was
20 in March of this year, and I can tell you where
21 it was, but I've been traveling so much I
22 forget what city. It was a combined conference
23 that we presented.

24 And I presented at the Catholic
25 Medical and Dental Association in Ridgecrest,

1 North Carolina, in May.

2 And I presented at the Support 4
3 Family Conference, in London, in June.

4 Q. Is that the extent of the
5 conference presentations you've given on trans
6 issues?

7 A. I don't want to misstate, but I
8 think, yes, that's it.

9 Q. Okay. Thank you.

10 A. Oh. Excuse me. I also presented
11 a case report in the Southern Pediatric
12 Endocrine Society, in Orlando, in March.

13 Q. Okay. Great. And just real quick
14 to clean up something from before. The Dhejne
15 study in Sweden, just talking about the control
16 group versus not issue that I think we agreed
17 we understood each other on. The study at no
18 point compares people who were affirmed through
19 social, medical and surgical treatment with
20 people who had gender dysphoria but were not
21 treated?

22 A. That's correct.

23 Q. Thank you. During the course of
24 the deposition today, you frequently referred
25 to a number of publications and sources from

1 your personal like data bank. To the extent
2 that those aren't already included in your
3 report, we'd like to request that you produce
4 them, but we can do that after we kind of comb
5 through the deposition. Like you can take the
6 time to see throughout the deposition, but we'd
7 like to request those studies and reports that
8 you developed your opinions upon.

9 MR. BLAKE: If you'd like to put a
10 list together and send it to us, we'll look to
11 see which ones were relevant and which ones
12 weren't.

13 MS. INGELHART: I mean, if they
14 were brought up today.

15 MR. BLAKE: Obviously, if he
16 relied on it in forming his opinion.

17 MS. INGELHART: Okay.

18 MR. BLAKE: Just because it was
19 brought up today, we covered a lot of terrain
20 which I would say is not relevant to his
21 opinion.

22 MS. INGELHART: I see what you're
23 saying.

24 MR. BLAKE: But if it's relevant
25 to his opinion, we'll absolutely produce it.

1 Relevant or relied on to his opinion, we'll
2 produce it.

3 MS. INGELHART: Okay.

4 BY MS. INGELHART:

5 Q. Speaking to that, are there any
6 other bases or sources besides what we've
7 discussed today that you're relying on to
8 provide your testimony?

9 A. I guess just sort of personal
10 conversations with mentors and colleagues.

11 Q. Okay. But no primary or
12 documented sources?

13 A. No.

14 MS. INGELHART: Thank you. We
15 don't have any more questions at this time.

16 MR. BLAKE: I just have a couple
17 of quick questions.

18 MS. INGELHART: Okay.

19 EXAMINATION

20 BY MR. BLAKE:

21 Q. Dr. Van Meter, there was a lot of
22 conversation today about religious beliefs and
23 personal beliefs. Do your religious or
24 personal beliefs prejudice you against
25 transgender people?

1 A. No. If anything, they increase my
2 compassion for those patients.

3 Q. Do you harbor any animose or
4 prejudice towards transgender people?

5 A. No.

6 Q. Do you believe that people who
7 suffer from gender dysphoria deserve compassion
8 and respect?

9 A. I certainly do.

10 Q. Are any of your opinions in your
11 expert report or rebuttal report based on
12 agenda or political beliefs?

13 A. No.

14 Q. What are your opinions in your
15 report and rebuttal based on?

16 A. Based on validated science, based
17 on the concept of being an advocate for
18 children.

19 Q. And is it your opinion that many
20 of the opinions in Dr. Ettner's report are not
21 based on valid medical science?

22 A. Yes.

23 Q. And have you changed any of your
24 opinions based on any of the exhibits you've
25 seen or testimony you've given today?

1 A. I did want to correct the one
2 reference that I obviously misquoted, and
3 that's the only thing I would change.

4 Q. And so all of your opinions remain
5 the same?

6 A. Yes.

7 MR. BLAKE: No further questions.

8 MS. INGELHART: None from us
9 either.

10 (Thereupon, the deposition was
11 concluded at 3:37 p.m.)

12 * * *

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PLEASE NOTE ANY STENOGRAPHIC OR TYPOGRAPHICAL ERRORS BELOW, FIRST IDENTIFYING THE PAGE AND LINE NUMBERS, AND THEN THE PROPOSED CORRECTION.

<u>PAGE</u>	<u>LINE</u>	<u>CORRECTION TO TEXT</u>
58	2	take out "court"
60	13	change "physiologist" to "psychologist"
91	7	change "medical" to "mental health"
94	3	change "arees" to "there is"
100	8	change "AD" to "eighty"
100	18	change "He's" to "She's"
103	1	change "malzgendmant" to "maladjustment"
117	4	change "in" to "and"
120	5	change "c211" to "cull"
128	3	add "Adult"
130	4/5	change "--" to "amniocentesis"
137	15	change "szys" to "h2s"
143	14	change "ASMA" to "asthma"
169	3	change "attenuation" to "iteration"
180	24	strike "wife" - misstatement by me
199	23	change "reorganization" to "re-orientation"
201	4	change "ACEC" to "ACE's"
207	8	change "probably 50%" to "12%" (I reviewed the actual data)
275	15	change "whip" to "whit"

Quinn L. V. Watson

30 October 2019

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I, QUENTIN L. VAN METER, M.D., do
hereby certify that the foregoing is a true and
accurate transcription of my testimony.

Quentin L. Van Meter

Dated *30 October 2019*

1 STATE OF OHIO)
2 COUNTY OF MONTGOMERY) SS: CERTIFICATE

3
4 I, Donald Correll, a Notary Public
5 within and for the State of Ohio, duly
6 commissioned and qualified,

7 DO HEREBY CERTIFY that the
8 above-named QUENTIN L. VAN METER, M.D., was by
9 me first duly sworn to testify the truth, the
10 whole truth and nothing but the truth.

11 Said testimony was reduced to
12 writing by me stenographically in the presence
13 of the witness and thereafter reduced to
14 typewriting.

15 I FURTHER CERTIFY that I am not a
16 relative or Attorney of either party, in any
17 manner interested in the event of this action,
18 nor am I, or the court reporting firm with
19 which I am affiliated, under a contract as
20 defined in Civil Rule 28(D).

21
22
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IN WITNESS WHEREOF, I have hereunto set
my hand and seal of office at Dayton, Ohio, on
this 11th day of October 2019.



Donald Correll
DONALD CORRELL
NOTARY PUBLIC, STATE OF OHIO
My commission expires 8-9-2022

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